Community Recreational Initiatives Society

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"TOGETHER WE MAKE A DIFFERENCE

PERSONAL HEALTH AND MEDICAL RECORD

The following information is used to provide CRIS personnel with an assessment of each volunteer's medical history for safety purposes. This information will remain confidential. Please be as detailed as possible.
It is your responsibility to update CRIS personnel of changes in your health/meds/etc. that occur after filling out your Health and Medical Record.
Please print clearly.

Today's date (d/m/y) ____/____/_____

Surname_________________________ First name_________________ Middle name__________________ Age_____________________

Date of birth (d/m/y) _____ /_____/_______ Gender (circle) M F First Language spoken__________ Height_____ Weight________

Address (street, city, prov, post code) ____

Home Phone____________Cell____________Other_____________Email____

EMERGENCY CONTACT

1. Name____________________Relationship______________Address____

   Home phone_______________Cell_______________Other____

2. Name____________________Relationship______________Address____

   Home phone_______________Cell_______________Other_______________

PHYSICIAN: Name_________________________Phone_____________________Address____
Insurance carrier_____________________Policy number____
Please Note: CRIS does not provide medical insurance for participants or personnel.

BC Medical Number: _______________________________________

ALLERGIES: (Food, medicines, insects, plants, chemicals) **Note ANY and ALL**. Explain signs, symptoms & treatment_________________
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Please check all that apply <u>This list is not complete.</u> Please specify any and all condition(s) or challenges you have. Explain in section that follows.

☐**Neoplasm (cancers)** Leukemia, Cancer	☐**Circulatory System** High or low blood pressure, Irregular heartbeat, Pacemaker
☐**Blood & Blood Forming Organs & Immune system** hemophilia, Anemia, HIV	☐**Digestive System** Ulcer, Irritable Bowel Syndrome, trouble swallowing
☐**Congenital & Chromosomal** Huntington's, Down's syndrome, FASD, Autism	☐**Respiratory System** Asthma, COPD

PERSONAL HEALTH AND MEDICAL RECORD

☐**Mental & Behavioral** Eating disorder, Schizophrenia, Anxiety, Depression, memory loss (short or long)	☐**Skin conditions** Lupus, Psoriasis, Eczema or dermatitis
☐**Nervous System** Cerebral Palsy, paraplegia, quadriplegia, Hemiparesis (right or left?) seizures, Neuropathy, spasticity	☐**Genitourinary system** Severe PMS or menstrual problems, Currently Pregnant or breastfeeding, urinary or bowel issues.
☐**Injury, or other consequences of external causes** Fractures or breaks, Surgeries, brain injury, amputation	☐**Musculoskeletal System and Connective Tissue** Osteoporosis, Arthritis, Scoliosis, neck/spine/back problems,
☐**Sensory** Deaf, partially deaf, blind, partially blind, visual neglect, depth perception, colour blindness	☐**Endocrine, Nutritional and Metabolic** Problems with: Appendix, Kidney, Liver, Thyroid, Gallbladder, Hernia, Diabetes, Hypoglycemia, Heartburn
☐**Other considerations** **Motion sickness, Fainting/dizziness, Intolerance to warm temperatures, Intolerance to cold temperatures, Intolerance to light, Hepatitis (A, B and/or C), Tuberculosis, Migraines, Sleepwalking**	

If you have checked any of the above boxes **please provide details** (date/s, treatment, current status etc. **Additional space on back of last page**

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Are you taking ANY medications? (Prescription, over the counter, homeopathics, herbal supplements) **Yes** **No** Please list them.

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Will you be bringing these medications with you when participating with CRIS? **Yes** **No** If Yes please bring DOUBLE the needed amount for the duration of the trip. The Trip Leader will carry the duplicates in case yours are lost.

Diet Restrictions: ____

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Please list any medical or physical concerns that have not been covered in the above answers that may affect your participation in programs offered by CRIS. (i.e. pain, range of motion limitations,)

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*****THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE AS OF*****

THIS DAY______________ **OF**________________ **20**______________
(Day) **(Month)** **(Year)**

________________________________ ________________________________
Participant Legal Name (print clearly) **Participant Signature**

SIGNED THIS DAY______________OF________________20______________
(Day) (Month) (Year)

________________________________ ________________________________
Name of parent or legal guardian (If under the age of 18 or unable to sign) Signature of parent