



MEDICAL INFORMATION FORM

Our activities can be strenuous and often offer exercise of a different nature than most participants are accustomed to. We do not want you to engage in activities that would be detrimental to your health or which would be opposed by your doctor because of recent illness, injury, or surgery. If you have any questions regarding your participation in any activity with Paddle In, please discuss them with your physician. We ask for the following information so we can be aware of potential problems and will be better able to help you to safely enjoy the activity.

Name: \_\_\_\_\_ Male/Female (circle one)
Mailing address: \_\_\_\_\_ Age: \_\_\_\_\_
\_\_\_\_\_ Height: \_\_\_\_\_
Ontario Health Card #: \_\_\_\_\_ Weight: \_\_\_\_\_

Please check the appropriate column

Table with 3 columns: Yes, No, Have you ever had. Rows include Allergies, Diabetes, Heart disease, Epilepsy, Asthma, High blood pressure, Back problems, Dislocations, Do you get cold easily?, Do you smoke?, Are you pregnant?, Are you currently under a doctor's care?, For what reason?, Are you taking medications?, For what reason(s)?, Do you have allergies to bug bites?, If so, do you carry medications? LIST:, Do you have any other conditions which might affect your health or the well being of others?, What are they?, Are there any limitations on your activities?, What are they?

Describe your swimming ability: \_\_\_\_\_

How would you describe your health? \_\_\_\_\_

In case of emergency, please notify: \_\_\_\_\_

At this daytime phone number: \_\_\_\_\_ or in the evening at: \_\_\_\_\_

Paddle In
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