Pointe Claire

Pointe-Claire Canoe Kayak Club

Please answer the following questions to the best of your ability.
This questionnaire is confidential and will kept as part of your file.
Its contents will only be disclosed if urgently requested or required by law.

General information

First name: _____
Last name: _____
Address: _____
_____

Date of birth: _____
Gender: _____
Medicare #: _____
Expiration date: _____ /____ (YYYY/MM)

Emergency Contact Information

Last name: _____
First name: _____
Relationship: _____

☏ Cell: _____
☏ Home: _____
☏ Work: _____
✉ Email: _____

Last name: _____
First name: _____
Relationship: _____

☏ Cell: _____
☏ Home: _____
☏ Work: _____
✉ Email: _____

Physical Health History

Y	N	General History
☐	☐	Recent concussion (date:_____)
☐	☐	Auto-injector (i.e. EpiPen)
☐	☐	Eyeglasses/contacts
☐	☐	Inhaler
☐	☐	Medic Alert bracelet - Please explain diagnosis & medical history:

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Hearing impairment
☐	☐	Hemophilia	☐	☐	Headaches/migraines
☐	☐	Diabetes	☐	☐	Skin condition
☐	☐	Hypoglycemia	☐	☐	Visual impairment
☐	☐	Seizure disorder	☐	☐	Digestive problems

Other / Details: _____

Restrictions:

Recent operations, illnesses, injuries:

Description	*Details (dates, treatment)*

Personal prescription, over-the-counter or alternative/complementary medication *(including birth control)*

Name of medication	Reason	Administered how/when
1.		
2.		
3.		
4.		

Allergy history

Detailed information required about all allergies to ensure adequate medical care, except for minor allergies.

Allergy _____

Allergens: _____

_____

Regular medications: (name/frequency)

_____

_____

Medications as required: (name/frequency)

_____

_____

Emergency measures: (type/instructions)

_____

_____

_____

_____

Nature of reaction:

Y	N		Y	N	
☐	☐	Rash / Hives	☐	☐	Anaphylaxis
☐	☐	Asthma	☐	☐	Other**:** _____

Current medical treatment:

Y	N		Y	N	
☐	☐	None			
☐	☐	Non-prescription medication			
☐	☐	Prescribed medication			
☐	☐	Other: _____			

Ability of the individual to manage:

Y	N		Y	N	
☐	☐	Recognizes the reaction on their own			
☐	☐	Can treat the reaction on their own			
☐	☐	Requires assistance from an adult			
☐	☐	Requires assistance from a medical professional			
☐	☐	Other: _____			

Other: _____

_____

Special needs, including emotional needs

Y	N		Y	N	
☐	☐	Concerns about coping (e.g. staying away from home, new situations)	☐	☐	Currently seeing a professional to address mental or emotional health concerns
☐	☐	Diagnosed with attention deficit disorder (ADD) or ADHD	☐	☐	Emotional health concern
			☐	☐	Learning disability
☐	☐	Victim of bullying	☐	☐	OCD, panic/anxiety

Please provide information about the individual's emotional health that may have been forgotten on this form. We are particularly interested in information that may affect the individual's to fully participate in our program.

_____

_____

_____

_____

Is there something we have forgotten? Please indicate any relevant information:

Additional information: _____

_____

_____

_____

_____

Signature: _____ ***Date:*** _____