

Teens Encounter Christ, Diocese of Fredericton, Medical Information

Name: _____
Age: _____ Birth Date: ___/___/___ Gender _____
DD/ MM/ YY

Home Address: _____
Phone: _____ Postal Code: _____
Family Physician: _____ Phone: _____
Medicare Number: _____

If under 18, please fill out the following information:

Father/Guardian Name: _____ Phone: _____
Mother/Guardian Name: _____ Phone: _____

If over 18, please give us an emergency contact name and number

Name: _____ Phone: _____

General Information

Please complete the section below by checking the condition(s) which apply.
Strict confidence will be kept.

Yes	No	Chronic Conditions:	Further Explanation or Treatment
___	___	Allergies	_____
___	___	Asthma	_____
___	___	Hay fever	_____
___	___	Diabetes	_____
___	___	Epilepsy	_____
___	___	Heart	_____
___	___	Sight	_____
___	___	Contact lenses	_____
___	___	Hearing	_____
___	___	Headaches	_____
___	___	Hyperactivity	_____
___	___	other (specify)	_____

3. Medication Policy is that the team member will hold and administer their own medication.

Will you be on medication during the weekend? Yes ___ No ___

If yes, please specify particulars: medication _____

Reason _____

Instructions _____

2nd medication _____

Reason: _____

Instructions _____

Do you have food allergies or concerns (i.e. vegetarian, etc?)

I or the parent(s) or guardian(s) of the above-named person, I/we hereby state that the information stated above is correct and true to the best of my/our knowledge. I/we authorize the Members of the CORE Team to administer first aid and to secure such medical advice and services as deemed necessary for the health and safety of the above-named person. I/we further authorize the above-named person to be transported in a private vehicle if necessary to secure such medical assistance.

Signature of Parent(s) or Guardian(s) or Team Member if 18 years or older

_____ Date: _____