

Participant Medical Information Form



The information collected is protected by the Protection of Privacy provisions of *The Freedom of Information and Protection of Privacy Act*.

Date: _____ **Session:** _____

If attending a Youth Action Centre or Children's Drop-In program,

please indicate site: _____

Participant Information

Participant's Name: _____ **Birthdate:** _____

Address: _____ **Postal Code:** _____

Is this Participant currently on any medication? Yes No

If Yes, please specify _____

Does this Participant have food or any other allergies? Yes No

If Yes, please specify _____

Does this Participant require use of an Epi-Pen? Yes No

If Yes, do you want the program leader to administer it? Yes No

If Yes, Please provide staff with a completed **Epi-Pen Authorization and Release Form**

http://www.winnipeg.ca/cms/recreation/pdfs/Epi_Pen_Authorization.pdf

If No, please indicate the procedure you wish the leader to follow: _____

Emergency Contact

Parent / Guardian Name(s): _____

Home Phone: _____ **Work:** _____ **Cell:** _____

Alternate Contact Name: _____ **Relationship:** _____

Home Phone: _____ **Work:** _____ **Cell:** _____