

District of Squamish – Recreation & Culture Services

Medical Form – Parts 1 & 2.



PART 1. To be completed for a minor/child participating in a parent drop-off program such as Camps, After School Fun, LEAP, or Bike programs.

The information on this medical form is essential for the District of Squamish Recreation and Culture Department and its program staff. Providing accurate information – as it pertains to your child’s specific needs – allows staff to facilitate a positive learning environment that is safe, inclusive and fun for your child and other participants.

1. Does your child have a history of the following? Please indicate how your child is affected, any symptoms and what factors contribute to their onset.

Condition	Yes	No	Describe	Condition	Yes	No	Describe
Respiratory Problems				Allergies			
Diabetes				Behaviors			
Hypoglycemia				Other			

2. Please list any medications or prescriptions that your child will be bringing with them. **Note: Instructors/leaders will not administer any medication.**

3. Please list any additional information or suggestions to provide the appropriate support for your child, including accessibility needs/accommodations, triggers, learning differences, behaviour cues and/or strategies for communication.

This information is confidential. It enables the instructors/leaders to reduce the risk of injury or illness complications as well to prepare contingency plans if an emergency does occur.

I have honestly disclosed all the information requested; and I understand that withholding information may contribute to injury and/or illness, complications and possibly compromise the care provided in the event of an emergency. If any of the above information changes prior to or during the programs I will immediately notify a program instructor/leader.

I, _____ am the legal guardian of the participant

Signature

Date

DISCLAIMER: Personal information collected through this form is only for the purpose of understanding the medical needs of the participants. The collection, use, and disclosure of this personal information is subject to the provisions of the *Freedom of Information and Protection of Privacy Act*. Personal information collected through this initiative will only be used for the purpose of creating a safe environment for the participants and to achieve program goals. The information collected will be retained and dispositioned according to the *District of Squamish Records Retention and Disposal Bylaw No. 2622, 2019*, and the *District of Squamish Records Classification and Retention Schedule*. If you have any questions, please contact the Information and Privacy Supervisor at 604-815-4948.

District of Squamish – Recreation & Culture Services

Medical Form – Parts 1 & 2.



PART 2. To be completed if you are over 19yrs and you are registering for one or more Therapeutic Fitness programs.

The information on this medical form is essential for the District of Squamish Recreation and Culture department and its program staff. Providing accurate information – as it pertains to your ability to participate in physical activity – allows staff to facilitate a positive learning environment that is safe, inclusive and valuable to you, the participant.

1. Do you have a history of the following? Please indicate how you are affected, what symptoms you experience and what factors contribute to the onset.

Condition	Yes	No	Describe	Condition	Yes	No	Describe
Respiratory Problems				Allergies			
Diabetes				Parkinsons			
Stroke				Seizure			
COPD – chronic obstructive pulmonary disease				CVD – cardiovascular disease (heart attack/stroke/irregular heart rhythm)			
Other							

2. Please list any medications (with potential side-effects) that you are currently taking.

3. Please list any additional information or suggestions for us to provide you with the appropriate support, including accessibility needs/accommodations, learning differences, triggers and/or strategies for communication.

This information is confidential. It enables the instructors/leaders to reduce the risk of injury or illness complications as well to prepare contingency plans if an emergency does occur.

I have honestly disclosed all the information requested; and I understand that withholding information may contribute to injury and/or illness complications and possibly compromise the care provided in the event of an emergency. If any of the above information changes prior to or during the programs I will immediately notify a program instructor/leader.

I, _____ am the participant.

Signature

Date

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