Francisco Escobar
Owner/ Operator
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MEDICAL INFORMATION FORM

Participant info:

First name: _____ Last name: _____

Date of birth: _____/____/_____(dd/mm/yy)

Care Card Number _____

Address: Apt# _____ Street _____ City _____
Province _____ Postal Code _____.

State of physical condition: Excellent ____ Good ____ Average ____ Poor _____

Allergies: Yes_____ No _____ If yes, specify:
_____
_____.

Presently on medication (prescription or non-prescription): Yes____ No _____
If yes, specify:
_____
_____.

Chronic disability or illness: Yes _____ No ____ If yes, specify:
_____
_____.

Visual acuity (require glasses or contacts): Yes _____ No _____

History of joint injury or related chronic problem: Yes _____ No ____ If yes, specify:
_____
_____.

Do you feel you have any phobia: Yes ____ No _____ If yes, specify:
_____
_____.

Is there any other condition or particular behavioral concern we should be aware of:
Yes ____ No ____ If yes, specify: _____
_____
_____.

Emergency Contact Info:

Contact #1 First name : _____ Last name: _____.
Relation to participant: _____ Address: Same as participant yes ____.
Apt# _____ Street _____ City _____Province _____ Postal
Code _____Cellphone _____Work phone _____
Other _____.

Contact #2 First name : _____ Last name: _____.
Relation to participant: _____ Address: Same as participant yes ____.
Apt# _____ Street _____ City _____Province _____ Postal
Code _____Cellphone _____Work phone _____
Other _____.

Participant Signature: _____Date: _____ _(dd/mm/yy)

Parent/ Guardian signature if participant is a minor: _____

Important Note:

All personal and medical information will be kept private, confidential, and will only be used in the unlikely event of a medical emergency.

We are committed to providing the best experience possible to the participants and parent (s)/ guardian. If you have any questions or concerns, please do not hesitate to contact us at any time at 250-415-8257.