Participant Health Information Form

Participant Name: Last, First **Date:** DD / MM / YYYY

Information is confidential and used at the discretion of authorized Western Educational Adventures staff members to ensure proper healthcare is given to the participant.

General Information

Last Name: ______ First Name: ______

Middle Name: ______ Gender: ☐ Male ☐ Female ☐ Other

DOB: ______ Age During Program: ______

Address Line 1: ______ Address Line 2: ______

City: ______ Province: ______ Postal Code: ______

Home Phone: ______ Email (for payment): ______

PHN: ______ Province: ______ Doctor: ______ Phone: ______

Height(ft.): ______ Weight (lbs.): ______

Emergency Contact 1 *** must be available during contract*

Full Name: ______

Phone: ______ Email: ______

Work Phone: ______ Home Phone: ______

Emergency Contact 2 *** must be available during contract*

Full Name: ______

Phone: ______ Email: ______

Work Phone: ______ Home Phone: ______

Immunizations

Tetanus: ☐ No ☐ Yes Last Booster Date (every ten years): ______ DPT and Polio: ☐ No ☐ Yes Last Booster Date: ______

Have you been immunized? ☐ No ☐ Yes

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Health History	
Have you ever been diagnosed with an eating disorder/disordered eating or displayed similar symptoms?	☐ No ☐ Yes
If yes, please explain:	
Have you ever received a psychiatric diagnosis such as anxiety or depression?	☐ No ☐ Yes
If yes, please explain:	
Do you suffer from any emotional disorder that would prevent you from fully performing your contracted functions?	☐ No ☐ Yes
If yes, please explain:	
Is there anything else we should know about your well being?	☐ No ☐ Yes
If yes, please explain:	

Recent Illness, Operations, or Injuries	
Please inform us of any change in your well being before the program start date via email.	
Have you had any recent illnesses, operations, or injuries?	☐ No ☐ Yes
If yes, please explain the condition and treatment/medications given:	
Will this condition limit or affect your ability to perform your function?	☐ No ☐ Yes
If yes, please explain:	

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Dietary Requirements	
Do you have any specific dietary needs or requirements?	☐ No ☐ Yes
If so are they medically confirmed (if applicable)?	☐ No ☐ Yes
If yes, please provide details:	

Medications	
All medications must be in **original containers and clearly labeled**. If you are brining any we need to discuss proper storage and management as minors are around.	
Do you take/carry any medications?	☐ No ☐ Yes
If yes, please explain:	

Medically Confirmed Allergies	
Please state the name of substance, reaction that occurs, severity of reaction (mild, medium, severe, or life-threatening), and given treatment. Attach any pertinent information.	
Do you have any drug allergies?	☐ No ☐ Yes
If yes, please explain:	
Do you have any allergies to insect stings?	☐ No ☐ Yes
If yes, please explain:	
Do you have any seasonal allergies (eg., hay fever)?	☐ No ☐ Yes
If yes, please explain:	
Do you have any other allergies?	☐ No ☐ Yes
If yes, please explain:	

Do you carry an EpiPen or other auto-injector?	☐ No ☐ Yes	Do you wear a Medic Alert bracelet?	☐ No ☐ Yes
If you require an EpiPen, please bring a minimum of 2 in a waterproof container.			

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Other Health and Wellbeing Concerns

General Health Issues

Do you have any or ever experienced any of the following conditions: ☐ No ☐ Yes

If yes, please specify by checking the boxes below:

Condition		Condition		Condition	
Anaphylaxis	☐ No ☐ Yes	Eating Disorders	☐ No ☐ Yes	Motion Sickness	☐ No ☐ Yes
Anxiety/Depression	☐ No ☐ Yes	Fainting	☐ No ☐ Yes	Physical Limitations	☐ No ☐ Yes
Asthma	☐ No ☐ Yes	Hayfever	☐ No ☐ Yes	Raised Blood Pressure	☐ No ☐ Yes
Bleeding Issues	☐ No ☐ Yes	Head Lice	☐ No ☐ Yes	Seizures or Epilepsy	☐ No ☐ Yes
Brain Injury or Concussion	☐ No ☐ Yes	Hearing Impairments	☐ No ☐ Yes	Skin Conditions	☐ No ☐ Yes
Chest or Lung Disease	☐ No ☐ Yes	Heart or Circulatory Disease	☐ No ☐ Yes	Sleep Walking	☐ No ☐ Yes
Cold/Sinus Issues	☐ No ☐ Yes	Hypertension	☐ No ☐ Yes	Urinary Tract Infections	☐ No ☐ Yes
Diabetes	☐ No ☐ Yes	Insomnia	☐ No ☐ Yes	Vision Impairments	☐ No ☐ Yes
Digestive or Bowl Disorder	☐ No ☐ Yes	Joint Injury or mobility issues	☐ No ☐ Yes		
Earache/Infections	☐ No ☐ Yes	Migraine/Headaches	☐ No ☐ Yes		

If yes to any, please explain:

Any Additional Information

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Health Form Terms and Conditions v1.0 May 11th, 2023

PLEASE READ THIS AGREEMENT CAREFULLY AS IT IS LEGALLY BINDING

EVACUATION, MEDICATION, EMERGENCY TRANSPORTATION AND MEDICAL CARE: In the event that you (hereinafter referred to as the "Participant") are sick or injured, WEA staff and volunteers may give medication, first aid and/or take the Participant to a medical facility at their discretion. In the event of a serious medical emergency, WEA staff will notify an emergency contact as soon as practicable. WEA will work with the emergency contact to make arrangements for transportation and care of the Participant requiring medical attention. More serious medical emergencies may require our staff to make decisions and inform the emergency contact of their decisions when possible. All costs and expenses related to any evacuation (for any reason), medical care, transportation and/or emergencies are the responsibility of the Participant. The Participant will immediately reimburse WEA for any expenses WEA pays on behalf of the Participant. The Participant will immediately reimburse WEA for any evacuation, medication, emergency transportation and/or medical care expenses WEA pays on behalf of the Participant.

PAYMENT FOR UNEXPECTED EXPENSES INCURRED BY WEA ON BEHALF OF THE PARTICIPANT: In the event WEA pays an unexpected expense on behalf of the Participant such as for medical transportation, etc. the Participant must reimburse WEA within 14 days of WEA notifying them of the expense. 2%/month interest fee may be charged for unpaid expenses.

INFORMATION SHARING: I give permission for this health information to be shared with Western Educational Adventures Inc. staff and outside medical personnel as necessary.

COMPLETENESS OF INFORMATION: I hereby certify that all information in this form is accurate and up to date. All medical problems or conditions requiring ongoing medical supervision or care have been fully noted. I will contact Western Educational Adventures Inc. as soon as possible if any changes occur in my health status.

By completing, signing and submitting this registration form, I the Participant acknowledge to having read and agreed to the above Health Form Terms and Conditions.

By signing this agreement, I acknowledge that I am nineteen (19) years of age or older.

Participant:

Signed this ___ day of____________________, 20__

_________________________________ _____________________________

Participant Full Name Participant Signature

Witness:

Signed this ___ day of____________________, 20__

_________________________________ _____________________________

Witness Full Name Witness Signature

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