



BCKC - Medical and Emergency Information Form

Name: _____ Phone #: _____

Address: _____

Name and phone number of emergency contact: _____

Health Card Number: (optional) _____

Your doctor's name and phone number: _____

City your doctor's practice is in: _____

1) Any medical conditions or health concerns (contact lens, fainting, seizures, epilepsy, etc.):

None known to me: _____ (initial)

2) Medication you must/should take daily (iron supplement, prescription drugs, insulin, etc.):

None: _____ (initial)

3) Any recent injuries or operations, which might affect your participation in this activity?

None: _____ (initial)

4) Any allergies? (food, animals, plants, pollens, bees, fragrances, etc.)

None: _____ (initial)

SIGNATURE: _____ DATE: _____