Solstice Rock Guides
Medical Form

The following information is used to identify any medical related and contact information for each participant. Each participant must fill out the required information in order to participate in Solstice Rock Guides programs. The information that you provide is strictly confidential and is shredded at the completion of your program.

Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

BC Medical #_____ Family Physician_____

Current Medications: _____

Allergies: ____yes____no. If yes please detail: _____

Do you carry an Epi-Pen for these Allergies: _____yes _____no_____N/A

Please check if any of the following apply to you:

___Asthma	____Glasses	____Angina	____Seizures
___Diabetes	____Pregnant	____Back Pain	____Hearing Impaired.

Are there any other medical related issues that Solstice Rock Guides should be made aware of:
___yes ____no. If yes please explain._____

Emergency Contacts:

1 Name:_____Relationship_____
Home Phone:_____Work Phone:_____

2 Name:_____Relationship_____
Home Phone:_____Work Phone_____

Medical Treatment Consent:

"While my underage child is participating in Solstice Rock Guides programs I hereby give permission for Solstice Rock Guides staff to provide treatment and if needed to arrange medical transportation for them".

_____ _____
Parent / Legal Guardian Signature Date

_____
Please Print Full Name: