Medical Information

If you have any confidential concerns this page may be submitted directly to our Medical Coordinator Christine Gates at christineg69@live.ca.

FIRST NAME: _____ LAST NAME: _____

HOSPITALIZATION #: _____

FAMILY DOCTOR: _____ PHONE NUMBER: _____

Check the boxes that apply to you:

☐ Asthma/ Bronchitis	☐ Blood Transfusion	☐ Bowel Problems	☐ Chest Pain	☐ Deafness/ Hearing Problem	☐ Dental Problems
☐ Diabetes	☐ Eye Problems	☐ Fainting Spells	☐ Glasses/ Contacts	☐ Head Injury	☐ Heart Problems
☐ Hepatitis	☐ Kidney Problems	☐ Menstrual Problems	☐ Neck/Brain Disorder	☐ Nose Bleeds	☐ Psychiatric Disorders
☐ Seizures	☐ Thyroid Disorder	☐ Ulcers	☐Urinary Infections	☐ Recent Surgery	

Any other health concerns/problems:

_____

_____

_____

Special Diet: YES ☐ NO ☐ Specify: _____

Allergies: YES ☐ NO ☐ Specify: _____

Medications: YES ☐ NO ☐ (*Please list all medications below, including the dosage and frequency)*

_____ _____

_____ _____

_____ _____

Please use an additional piece of paper if necessary to list all medications and any additional medical information you feel our medical team should be aware of. Your cooperation is much appreciated.

Signature: _____ Date: _____

(Parent or Guardian if under 18)

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