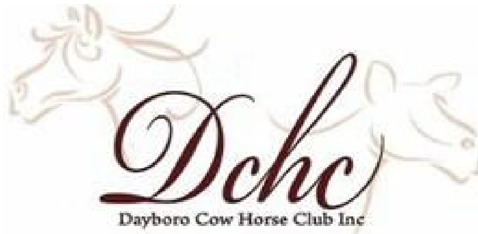

MEDICAL PROFILE

NAME: ____ Date of Birth:__________________

Please complete one Medical Profile for each person covered by membership.
Read the following questions and answer appropriately. The information collected will remain confidential and only be accessed by a First Aid Officer in case of emergency.

1. Are you currently taking any medication, whether prescribed or otherwise?
NO YES please supply details:__________________________________

2. Do you suffer from any illness or disease that DCHC should be aware of?
NO YES please supply details:__________________________________

3. Do you suffer from any disability that DCHC should be aware of?
NO YES please supply details:__________________________________

4. Is there any medical condition not mentioned above which may require treatment, which DCHC should be aware of?
NO YES please supply details:__________________________________

5. Are you allergic to any medication?
NO YES please supply details:__________________________________

6. Do you have any other allergies DCHC should be aware of?
NO YES please supply details:__________________________________

7. Please list your recent injuries (within past 2 years)
____

8. Do you have any recurring injury DCHC needs to be aware of?
NO YES please supply details:__________________________________

9. Please provide any further details of health or injury status that DCHC should be aware of
____

10. Please provide details of your primary medical providers
____

11. Please provide the name and an emergency contact number for next of kin
____

This form was completed by ____________________________ Date:___________________

Signed _____________________________Committee Member to sign: _________________