

**Confidential**

**Rowing PEI Medical, Wellness and Emergency Information Form (2020)**

ROWER’S INFORMATION:

First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date: day: \_\_\_\_ month: \_\_\_\_ year: \_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(C)

EMERGENCY CONTACT INFORMATION:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_(H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(C)

Family doctor’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s office telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PEI health card number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical considerations:

Dietary Info:

 \_\_Vegetarian \_\_Vegan \_\_Lactose Intolerant \_\_Gluten Free \_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_

Food allergy or sensitivity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Life Threatening? \_\_Yes \_\_No \_\_\_

Drug allergy or sensitivity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Life Threatening? \_\_Yes \_\_No \_\_\_

Other history of allergies or health sensitivities:

\_\_\_Asthma Life Threatening? \_\_Yes \_\_No

 \_\_\_Diabetes Life Threatening? \_\_Yes \_\_No

 \_\_\_Epilepsy / Seizures Life Threatening? \_\_Yes \_\_No

 \_\_\_Heart condition Life Threatening? \_\_Yes \_\_No

\_\_\_Back or other joint problems Life Threatening? \_\_Yes \_\_No

\_\_\_Rash/skin conditions Life Threatening? \_\_Yes \_\_No

 \_\_\_Recent illness or surgery Life Threatening? \_\_Yes \_\_No

Any other disability/condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you or anyone in your immediate family been stricken by COVID-19 \_\_\_\_\_\_\_\_\_

If so, please describe their condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any special habits, fears or anxieties related to water activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a concussion? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please describe what happened and what precautions you may need to take on the dock: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Health Information (e.g., current medications):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Rower / Rower’s Parent or Guardian if under the age of 18

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_