



Eastern Canada District
Of Key Club International
HEALTH FORM / MEDICAL RELEASE

Name _____ Birth Date _____ Sex _____

Address _____ City _____ Prov./Country _____ Postal Code _____
Phone (____) _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Address _____ City _____ Prov./Country _____ Postal Code _____
Phone (____) _____

IF EMERGENCY CONTACT NOT AVAILABLE, CONTACT:

Name _____ Relationship _____

Address _____ City _____ Prov./Country _____ Postal Code _____
Phone (____) _____

DOCTOR:

Name _____

Address _____ City _____ Prov./Country _____ Postal Code _____
Phone (____) _____

1. Are there any limitations in physical activities? ____ Yes ____ No
2. Are you allergic to any food or medication? ____ Yes ____ No
3. Are you currently under any medication? ____ Yes ____ No
4. Is there any other medical information that the District Administrator should know about you?
____ Yes ____ No

If you answered yes to any of the above questions, please attach a statement explaining.

Name of Health Insurance Company _____

Health Insurance Policy Number _____

In signing this form, I hereby certify that this information is correct. In case of medical emergency, I understand that every effort will be made to contact the named person or backup person named above. In the event that neither person can be reached, I hereby give permission to the District Administrator or their designate to notify a physician and I give permission to that physician to hospitalize, secure proper treatment for, and to order injection anesthesia or surgery for the participant above.

Signature of parent or guardian

Date