



Prairie Women on Snowmobiles Inc.

Head Office

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Medical Information Form

This form must be completed by each participant and returned to Prairie Women on Snowmobiles Inc. Disclosures made on this form and all information is completely confidential. Please print in ink.

First Name:			
Last Name:			
Your medical insurance Policy:			
Name of plan/name of company providing plan:			
Phone number for plan:		Plan's reference #:	
Do you have any dietary restrictions or allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please describe:			
What was the date of your last Tetanus inoculation or booster? (Must be current!)	Month:	Year:	
Please list any/all medical conditions, (heart disease, diabetes, etc.) psychological and physical conditions (seizure disorders, depression, bad back, joint problems, etc.) that may affect your ability to participate in the Mission. Please describe all past and present problems, how they affect you, what are the symptoms of onset, and what brings them on:			
Please list any medical conditions, both prescription and non-prescription, that you will be bringing with you on the Mission. Please list the name of the medication, the reason it is taken, the instructions for frequency and dosage:			

If you are bringing a medication with you, please do the following:

- List detailed dosage and frequency instructions on the outside of each container. Include the name of the drug as well.
- Pack it in a waterproof container.
- Ensure that it has not expired!

Do you have any allergies or have you had a severe allergic reaction? Check one: Yes No

If you checked "yes" please describe what causes reaction, what happens, medications you take or carry for the condition, and expiry date:

Name and telephone numbers of persons or call in case of an emergency. For the phone numbers, include area codes.

1 st choice name:		Relationship:	
Home phone:		Business phone:	
Best time to reach at this number:		Best time to reach at this number:	

2 nd choice name:		Relationship:	
Home phone:		Business phone:	
Best time to reach at this number:		Best time to reach at this number:	

Physician's name:			
Contact number:		Alternative contact number (optional)	
Best time to reach at this number:		Best time to reach at this number:	

I have completed this medical form, accurately and truthfully, to the best of my knowledge. I understand that any injury or illness that is aggravated by, or a result of my participation in this Mission and any evacuation cost arising thereof, is solely my own responsibility and I hereby release Prairie Women on Snowmobiles Inc. from any future claims I might make against them. I understand that it is my responsibility to inform the executive of Prairie Women on Snowmobiles Inc., before the Mission begins, of any medical conditions that may have arisen after completing this form.

Signed this _____ day of _____, 20__.

Signature of Participant

Print name of Participant