|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** |  | | | | | | **Date:** | |  | |
| **Address:** | |  | | | | | **Postal Code:** | | |  |
| **Date of Birth:** | | |  | | **Medical Care Card #** | | |  | | |
| **Home Phone #:** | | |  | **Cell #:** |  | **Email:** | |  | | |



**VOLUNTEER MEDICAL FORM**

**It is very important that we have on file updated medical information to complete registration. Please complete ALL BOXES on your Medical Form and the Volunteer Choice Form and e-mail both forms to:**

[volunteerSOBCabbotsford@gmail.com](mailto:volunteerSOBCabbotsford@gmail.com)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal Medical Information** | | | | | | | | | | | | | | | | | | | |
| **Doctor’s Name :** | |  | | | | | | | | **Doctor’s Phone #** | | | | |  | | | | |
| Do you have: | Glasses: | | | | Contacts: | | | Hearing Aid: | | | | Dentures: | | | | | None: | | |
| Heart Condition | | | Yes: |  | | No: |  | | High Blood Pressure: | | | | | Yes: | |  | | No: |  |
| Diabetic: | | | Yes: |  | | No: |  | | Tetanus Shot: | | | | | Yes: | |  | | No: |  |
| Asthma: | | | Yes: |  | | No: |  | | Cerebral Palsy: | | | | | Yes: | |  | | No: |  |
| Seizures: | | | Yes: |  | | No: |  | | Seizure Type: | |  | | | | | | | | |
| Seizure Treatment: | | |  | | | | | | | | | | | | | | | | |
| Allergies: | | | Yes: |  | | No: |  | | Specify Allergies: | | | |  | | | | | | |
| Other Medical Conditions: | | |  | | | | | | | | | | | | | | | | |
| Medication you are taking: | | |  | | | | | | | | | | | | | | | | |

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| --- | --- | --- | --- |
| **Emergency Contact information** | | | |
| Name of Contact : |  | Phone #: |  |
| Name of Contact : |  | Phone #: |  |