|  |  |  |  |
| --- | --- | --- | --- |
| **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

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| --- |
| **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: |  |

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