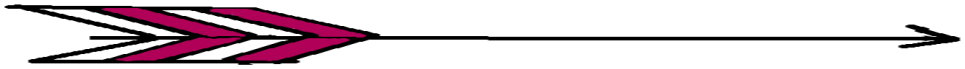
Kanata Archery Club



Medical Form

Last Name: _____ First Name: _____

Age: _____ Gender M: ☐ F: ☐

OHIP Number: _____ DOB: _____

Primary Contact in Case of Emergency

Last Name: _____ First Name: _____

Home Phone: _____ Cell Phone: _____

Secondary Contact

Last Name: _____ First Name: _____

Home Phone: _____ Cell Phone: _____

Family Doctor: Name: _____ Phone: _____

Relevant Medical History
Medications (Please indicate if archer needs assistance in medicating him/herself)

Allergies

Previous Injuries

Other conditions / information

Parent / Guardian

Signature: _____ Date: _____