





## MEDICAL RELEASE FORM

A. Name of Applicant: \_\_\_\_\_ Age at time of travel: \_\_\_\_\_

B. Rate your present health:

Excellent  Above Average  Average  Below Average  Poor

List any allergies you have: \_\_\_\_\_

List any special diet requirements: \_\_\_\_\_

List any medical conditions that you have that can or may affect your trip experience and/or may require the assistance of another person on a regular or emergency basis: (Eg. Epi pin administered when stung by bee)

C.  I will obtain personal medical insurance to cover the time frame I am out of country as well as any applicable vaccinations

### Information to be completed by parent if traveller under 18 or by self if over 18

Name of Parent: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Business: \_\_\_\_\_

Check box if Applicant has had any of the following:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Chicken Pox          | <input type="checkbox"/> Appendicitis         | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Measles (red)        | <input type="checkbox"/> Frequent Colds       | <input type="checkbox"/> Toothaches     |
| <input type="checkbox"/> Measles (german)     | <input type="checkbox"/> Hay Fever            | <input type="checkbox"/> Mumps          |
| <input type="checkbox"/> Epilepsy or fainting | <input type="checkbox"/> Severe Stomach Aches | <input type="checkbox"/> Hepatitis      |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Tonsillitis    |
| <input type="checkbox"/> Ear trouble          | <input type="checkbox"/> Sinusitis            |   |

Information about special conditions: \_\_\_\_\_

To the best of my knowledge, my child is in good health. In the case of medical emergency, I understand every effort will be made to contact parents or guardian. In the event I cannot be reached, I hereby give permission to the physician selected by the Team Leader to hospitalize, secure proper treatment, order injections, anesthesia or surgery for my child as named above.

Date \_\_\_\_\_ Parent's Signature \_\_\_\_\_

**Please note:** When all pages of this form are completely filled out, send to:  
Randy Balzer, P.O. Box 295 Plattsville Ont, N0J-1S0 or scan and send to [randy.balzer@accmbc.org](mailto:randy.balzer@accmbc.org)  
Fax: 519-684-7204