Celtic Fire Memorial Ride

Medical Information Sheet

Name: _____

Date of Birth: _____

Address: _____

Province: _____

Postal Code: _____

Telephone: (_____)_____

Health Card Number: _____

Alternate emergency contact:

Name: _____

Relationship to Rider:_____

Telephone: _____

Doctor's Name: _____

Phone: (_____)_____

Dentist's Name: _____

Phone: (_____)_____

Please check the appropriate response and provide details below if you've answered "yes" to any of the questions.

Yes ☐ No ☐ Medications

Yes ☐ No ☐ Allergies

Yes ☐ No ☐ Previous history of concussions

Yes ☐ No ☐ Previous history of fainting or seizures

Yes ☐ No ☐ Rx eyewear

Yes ☐ No ☐ Contact Lenses

Yes ☐ No ☐ Dental appliance

Yes ☐ No ☐ Hearing problems

Yes ☐ No ☐ Asthma

Yes ☐ No ☐ Other respiratory issues

Yes ☐ No ☐ Heart Condition

Yes ☐ No ☐ Family history of heart disease

Yes ☐ No ☐ Diabetes (please specify Type 1 or 2)

Yes ☐ No ☐ Wears a medical information bracelet/necklace

Yes ☐ No ☐ Had an illness that lasted more than a week and required medical attention in the past year

Yes ☐ No ☐ Had injuries that required medical attention in the past year

Yes ☐ No ☐ Been admitted to the hospital in the past year

Yes ☐ No ☐ Surgery in the past year

Yes ☐ No ☐ Presently injured

Yes ☐ No ☐ Vaccinations up to date

Yes ☐ No ☐ Covid vaccinations up to date

Yes ☐ No ☐ Hepatitis B vaccination

Please provide details if you answered "Yes" to any of the above (use the back of this form if additional space is required)

_____

_____

_____

_____

Medications:_____

Allergies:_____

Medical Conditions: _____

Recent Injuries:_____

Any Information not covered above:_____

_____

List any procedures or treatments you do not consent to:

_____

I consent to this form being accessed and reviewed in the event of injury or medical emergency. I further consent to this form - and any information within - being shared with first responders and/or medical personnel. This form will be destroyed at the conclusion of the ride, none of this information will be shared with any other parties. I understand the completion of this form is voluntary.

Name: _____ Signature: _____

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Additional Information: