SECOND SIXTIES OUTDOOR CLUB

NAME: _____

First Last

MEDICAL INFORMATION (* means information is required)

ALBERTA HEALTH CARE NO* _____

DATE OF BIRTH* **(Month/Day/Year)** _____/_____/_____

Primary EMERGENCY CONTACT NAME/NUMBER(S)*
_____/_____/_____

Backup EMERGENCY CONTACT NAME/NUMBER(S)*
_____/_____/_____

DOCTOR'S NAME/NUMBER:
_____/_____

MEDICAL CONDITIONS (Current)

MEDICAL CONDITIONS (Previous, including knee/hip replacements)

MEDICATIONS (Drug type/Dosage)

ALLERGIES _____

CONTACT LENSES: **(Yes/No)** _____

BLOOD TYPE: **(if known)** _____

Form Revised 2/33 **Use the reverse of the form if you need to show more medications.**