



RICHMOND CENTRE FOR DISABILITY

Personal Health Form

The information on this form will be used at the discretion of the event supervisor/coordinator to ensure care and attention is given to the health of the participants. All information on this form is considered **Personal and Confidential**. Please return this form to the responsible RCD staff.

Participant Name: _____ Telephone: _____

Address: _____

City _____ Postal Code _____

Contact in an emergency:

Name: _____ Telephone: _____

Name: _____ Telephone: _____

Address: _____
(if different from above)

City _____ Postal Code _____

Does the participant require special assistance in the area of physical activities? Yes No

If yes, please give specifics:

Does the participant have any special instructions for staff regarding his/her health conditions?

Is the participant currently subject to any chronic conditions or recent illnesses of which the staff should be aware of?

Every Care & Attention will be Given To The Health & Comfort of Participants.

I hereby authorize the RCD staff/coordinator responsible for the event to secure such medical advice and services as may be deemed necessary for the health and safety of myself. I agree to accept financial responsibility in excess of the benefits allowed by the RCD Insurance Plans.

Signature of Participant: _____ Date: _____

THIS FORM IS VALID FROM JULY 4 - AUGUST 29