

# American Canoe Association Paddlesport Training

## Participant Medical Information

In the interest of your safety and well being it is imperative that you disclose specific pertinent and current medical information. All information is strictly confidential and will only be communicated to medical professionals in the event of an accident or medical event. Thanks for you cooperation and compliance in this important matter.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Gender \_\_\_\_\_  
Emergency Contact Information:  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone # Work \_\_\_\_\_ Home \_\_\_\_\_  
Personal Physician \_\_\_\_\_ Phone # \_\_\_\_\_  
Medical/ Health Insurance Company \_\_\_\_\_  
Policy # \_\_\_\_\_ Company contact# \_\_\_\_\_

Do you have any permanent or temporary physical or health conditions that would limit your ability to participate in any paddlesport training activities? no yes  
Do you have any chronic or recurring injuries? no yes  
Are you taking any medications (OTC or prescription) at this time? no yes  
Do you have any allergies or reactions to any foods, plants, medications or insects that you are aware of at this time? no yes  
Have you had any surgery(s) or medical procedures in the last 5 years which would limit your participation in vigorous paddlesport training? no yes  
If you answered yes to any of the above please give history and explanations:

Do you have a history of:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Skin conditions
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hearing issues
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> TB
<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Hernia/ Rupture
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Convulsions/ Epilepsy
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ulcers/Stomach/Digestive Issues
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Alcohol/ Substance Issues
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Other Issues	

If you answered yes to any of the above please explain: \_\_\_\_\_

Do you have any issues with your eyes or vision? no yes  
Do you wear corrective contact lens or eyeglasses? no yes  
Are you pregnant? no yes

Resting Vitals:

Blood Pressure \_\_\_\_\_ Heart Rate \_\_\_\_\_

Please use the back of this form to convey any other pertinent medical or health information