



Notes:

1. The information on this form may be used by and shared with GGC representatives or medical personnel to administer or authorize appropriate medical attention for you.
2. Completion of this form is required for overnight activities and Red level activities.
 - a. Please keep this form in your bag/with your belongings and inform the Responsible Guider or another participant of its location (or you may hand it in to Responsible Guider for the activity).
 - b. For **adventure camping, adventure tripping and travel over 72 hours** it must be provided to the first aider.
3. If you have a life-threatening or health related condition that could affect your ability to supervise girls, please see Safe Guide for further information.
4. If you have any disabilities that may require accommodation, disclosing and discussing them with us will help us accommodate you.
5. You may need to review and update this form periodically throughout the year.

Name

Last name

First name

Address

No.

Street

Apt. No.

P.O. Box or R. R. No.

City

Province/Territory

Postal Code

Phone: Home ()

Cell ()

Business ()

In an emergency, please notify:

Last name

First name

Relationship

Phone: Home ()

Cell ()

Business ()

Address (if different from above)

No.

Street

Apt. No.

P.O. Box or R. R. No.

City

Province/Territory

Postal Code

Family doctor (optional)

Phone ()

Provincial health insurance number (optional)

The activity/event/camp may include swimming hiking, boating, pitching tents, etc. Do you have **any physical, cognitive, emotional or behavioural limitations/challenges** that would require assistance and/or modifications to enable you to participate fully? ☐ Yes ☐ No If yes, please provide details:

Do you have any special instructions for Guiders/staff regarding your **health care and/or diet**?

☐ Yes ☐ No If yes, please explain:

Do you wear contact lenses? ☐ Yes ☐ No

If you have **allergic reactions** to such things as food, insect stings, etc., please complete the following:

Allergy	Life-Threatening?	Allergy	Life-Threatening?
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No



Medications: Any medication (over-the-counter and/or prescribed) must be brought by you.

Do you carry an asthma pump, Epi-pen or other medication?

☐ Yes ☐ No If yes, please specify: _____

Only complete the following for Adventure Camping or Adventure Tripping

Are you subject to any of the following? (Please check all that apply):

- | | | | | |
|--|--------------------------------------|--|-------------------------------------|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Motion sickness | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Respiratory ailments |
| <input type="checkbox"/> Ear trouble | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sleep walking | <input type="checkbox"/> Nightmares | |
| <input type="checkbox"/> Other – please specify: _____ | | | | |

Chronic conditions or recent illnesses:

Please provide details of treatment required and name of medications you are bringing with you and which of the above condition(s) they are for

N. B. Every care and attention will be given to the health and comfort of the participant.

I hereby authorize a GGC representative to provide first aid and/or secure such medical advice and services (e.g., contacting EMS/ambulance) as may be deemed necessary for my health and safety. I agree to accept financial responsibility in excess of the benefits allowed by my provincial/territorial health plan

Signature of participant: _____ Date: _____

UPDATED:

Signature of participant: _____ Date: _____

This form is valid for one year. Update may be required during this period.