

Miss New Westminster Ambassador Programme

Official Medical Form

This form must be completed and signed by your physician

Cost of completion of form to be born by the applicant.

As noted in Rule #5, a pre-requisite for entry in to the Miss New Westminster Ambassador Programme is completion of this medical form signed by your doctor stating that you have been examined and are in good health. In addition, for your protection in an emergency away from your own doctor, it has proven helpful to list any known allergies or hypersensitivity to medication, drugs, antibiotics, etc. Please also mention any current medication or any other pertinent surgical history.

NAME _____
first middle last

ADDRESS _____

TELEPHONE:(HOME) _____ (CELL) _____ (PAGER) _____

BIRTHDATE _____ BIRTHPLACE _____

IMPORTANT INFORMATION:

B.C PERSONAL HEALTH NUMBER (CARECARD): _____

DENTAL CARD # (if applicable): _____

OTHER MEDICAL CARD # (if applicable): _____

DOCTOR'S NAME: _____ DOCTOR'S NUMBER: _____

DENTIST'S NAME: _____ DENTIST'S NUMBER: _____

GENERAL INFORMATION:

IS THERE ANY MEDICAL CONDITION WE SHOULD BE AWARE OF? _____

IF SO PLEASE SPECIFY: _____

IS YOUR DAUGHTER ON ANY MEDICATION WE SHOULD BE AWARE OF? _____

IF SO WHAT IS IT AND HOW OFTEN MUST SHE TAKE IT? _____

HAS YOUR DAUGHTER EVER HAD AN ALLERGIC REACTION TO ANY MEDICATION THAT WE SHOULD KNOW ABOUT? _____

IF SO WHAT ARE THEY AND WHAT ARE THE REACTIONS WE SHOULD WATCH FOR? _____

DOES YOUR DAUGHTER HAVE ANY OTHER ALLERGIES TO ANYTHING ELSE, SUCH AS FOOD, SMOKE, DRY ICE, OR PLANTS? _____

IF SO WHAT ARE THEY AND WHAT ARE HER REACTIONS? _____

IS YOUR DAUGHTER ALLERGIC TO BEE STINGS? _____

IF SO DOES SHE CARRY A NEEDLE KIT? _____

DOES SHE KNOW HOW TO USE IT? _____

WHEN WAS HER LAST TETANUS SHOT? _____

DO YOU GIVE US PERMISSION TO GIVE HER TYLENOL OR ASPRIN IF SHE NEEDS IT? _____

IN CASE OF EMERGENCY:

CONTACT PERSON: _____

CONTACT NUMBER (H): _____

RELATIONSHIP: _____

(W): _____

CONTACT PERSON: _____

CONTACT NUMBER (H): _____

RELATIONSHIP: _____

(W): _____

IF WE CANNOT REACH THE ABOVE CONTACTS, DO YOU GIVE THE CHAPERONE PERMISSION TO ACT ON ANY MEDICAL SERVICES THAT SHE/HE FEELS ARE NEEDED FOR YOUR DAUGHTER'S HEALTH? _____

PLEASE SPECIFY ANY OTHER INSTRUCTIONS THAT YOU FEEL THE CHAPERONE SHOULD CONVEY TO AN EMERGENCY DOCTOR:

PHYSICAL EXAMINATION:

HEIGHT: _____ WEIGHT: _____ BLOOD TYPE: _____

SURGICAL HISTORY _____

MEDICAL HISTORY (INCLUDING ALLERGIES, MEDICATIONS ETC) _____

SIGNATURE OF DOCTOR

DATE

PRINT NAME OF DOCTOR

ADDRESS OF DOCTOR

ACKNOWLEDGMENT:

I _____ (print parent or legal guardian's name) HEREBY ACKNOWLEDGE THAT ALL OF THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE, AND ACCEPT ALL LEGAL RESPONSIBILITY WHILE MY DAUGHTER IS UNDER THE MISS NEW WESTMINSTER AMBASSADOR PROGRAMME'S CARE. I ALSO AGREE, BY SIGNING THIS FORM, THAT WE WILL NOT TAKE ANY LEGAL ACTION AGAINST THE HYACK FESTIVAL ASSOCIATION, THE AMBASSADOR COMMITTEE, OR ANY ASSIGNED CHAPERONE IF THEY ARE UNABLE TO REACH US OR THE ABOVE EMERGENCY CONTACT PEOPLE.

CONSENT:

I _____ (print parent or legal guardian's name) HEREBY GIVE CONSENT TO THE MISS NEW WESTMINSTER AMBASSADOR COMMITTEE OR CHAPERONE TO OKAY ANY MEDICAL SERVICES THAT MY DAUGHTER _____ (print daughter's name) MAY REQUIRE IF THEY ARE UNABLE TO CONTACT EITHER OF THE TWO EMERGENCY CONTACT PEOPLE LISTED ABOVE.

Signature of Candidate

Date

Signature of Parent/Guardian

Print name of Parent/Guardian

Address of Parent/Guardian

Telephone Number of Parent/Guardian

Signature of Witness

Print name of Witness

If you have any questions regarding any of the above, please contact:
Chantel McIntyre, Co-ordinator, at 604 521-8523