

DELTA OUTRIGGER Kanu Association MEDICAL DISCLOSURE

PERSONAL INFORMATION

Name: _____ Birth Date: _____

Address: _____

Phone #: Home: _____ Bus: _____ Cell: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Swimming Ability: Excellent _____ Good _____ Fair _____ Poor _____

If any of the personal or medical information changes, please inform the Membership Representative of Delta Outrigger Kanu Association.

Signed: _____ Date: _____

MEDICAL INFORMATION

Asthma: _____ Rheumatic Fever: _____ Epilepsy: _____ Diabetes: _____

Abnormal Heart Condition: _____
(please describe) _____

History of Joint Injury: _____
(please describe and specify joint) _____

Allergies / Reaction: _____
(please list) _____

Medications: _____ Dose: _____ When Taken: _____

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Do you wear contacts? _____

Do you have physical limitations which would effect your participation in the activity of Outrigger?

Specify: _____

Do you have psychological limitations which would effect your participation in the activity of Outrigger? (ie; fear of water)

Specify: _____

Phone #:

Doctors Name: _____