



**MEDICAL FORM-**

**FAX: 416-619-4586**

Applicant's Full Name: \_\_\_\_\_

Male: \_\_\_\_\_ Female: \_\_\_\_\_

Birth date (mm/dd/year): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Height mts / feet (specify): \_\_\_\_\_

Weight kgs/ lbs (specify): \_\_\_\_\_

Address: \_\_\_\_\_

City/Prov/Postal/Zip: \_\_\_\_\_

Home phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Business phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Family physician: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Postal/Zip: \_\_\_\_\_

In case of emergency contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Business phone: ( \_\_\_\_\_ ) \_\_\_\_\_

**Condition & Symptoms:** Do you have now, or have had in the past, any medical condition we should know about?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medication:** List all medication currently being taken. Please bring a copy of your prescription or the prescription bottle along with two extra doses of each medication.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**Allergies:** List all allergies below. All allergy medication is required on trip.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

I hereby give consent to attend the Evolve Freestyle program (program), and I hereby grant permission for any emergency anesthesia, operation, hospitalization or other treatment which might become necessary. Evolve Freestyle (EF) must be aware of any medical condition in advance. Failure to disclose such information could result in serious harm to me and/or my fellow participants. If I arrive at the program with a pre-existing condition or injury which is not indicated on my medical form, and I am subsequently forced to leave the program because of that condition, I will not receive any refund of tuition. The information provided above is a complete and accurate statement of the physical and psychological factors, which may affect my participation in the Evolve Freestyle Program. I agree to indemnify and hold EF faultless if all relevant information is not disclosed. I also agree to notify EF should there be any change in my health status prior to beginning or during my program. I understand that during my participation in the EF program, EF has taken all necessary precautions to ensure safety, however it is impossible to guarantee absolute safety. I assume responsibility for my safety on the program and I agree to comply with the instructions and directions of EF staff members during the program.

\_\_\_\_\_  
**Applicant's Signature** **Date**

\_\_\_\_\_  
**PARENT'S OR GUARDIAN'S SIGNATURE** (if child is under 18) **Date**