



White Rock Youth Ambassador Program

c/o WRSS Chamber of Commerce • #100 15261 Russell Ave. White Rock BC V4B 2P7

MEDICAL INFORMATION AND RELEASE FORM

MEDICAL INFORMATION

Last Name: _____ First: _____ Middle: _____

Mailing Address: _____

City: _____ Province: B.C. Postal Code: _____

Phone: _____ Email: _____

Birthdate: (yy/mm/dd) _____ Medical Insurance # _____

Extended Medical # _____ Name of Doctor: _____

Are you currently taking any medication? Yes No If yes, please explain below

Do you have any allergies? Yes No If yes, please explain below

Do you have a medical history (e.g. Diabetes, Heart Disease, etc)? Yes No

If yes, explain below _____

Do you have any other specific medical requirements that we should know of?

Medical Contact in case of Emergency: (Name & phone numbers)

MEDICAL RELEASE INFORMATION

In the event the Ambassador shall become ill or injured, in the opinion of a representative of the White Rock Ambassador Program, the ambassador and his/her guardian (if the ambassador is under the age of majority) hereby give express authorization for a representative of the White Rock Ambassador Program to arrange medical services for the ambassador. The same express permission is granted without prejudice to chaperones or committee members which may be present, in the event that the appointed chaperone is either indisposed, unavailable or incapacitated in any way.

Ambassador Signature

Please Print Name

Date

Guardian Signature

Please Print Name

Date

Witness Signature

Please Print Name

Date