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