

Name:



Part C. Medical Form.

To be completed by the youth applicant and the Parent/Guardian/Worker.

NOTE: Please use black ink as this form needs to be copied.

Youth Applicant Information

Name:	M/F:	Age:
Phone #:	Date of Birth: DD / MM / YYYY	
Address:		
City:	Postal Code:	
Health Card #:		

Height:	Ft.	In.	Weight:	Pounds.
Does the youth applicant wear a MedicAlert?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
If YES, what condition?				
Are the youth applicant's immunizations up to date?		<input type="checkbox"/> Yes <input type="checkbox"/> No		

Youth's Doctor

Doctor Name:	
Phone (day):	Phone (night):
Does the youth applicant use a walk-in clinic instead of a family doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, which walk-in clinic does the youth applicant visit?	
Does the youth applicant see any medical specialists?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, why does the youth applicant see the specialist?	
Specialist Name:	Type of Doctor:
Phone (day):	Phone (night):

In case of emergency, notify...

Name:	Relationship to the youth:
Phone (day):	Phone (night):
Other contact info:	

NOTE: This person must be accessible for the duration of the trip. Please list all possible contact numbers.

Parent / Guardian (if different from contact person)

Name:	Relationship to the youth:
Phone (day):	Phone (night):
Address:	

Name:

Part C, continued. To be completed by the Youth and the Parent/Guardian/Worker.

NOTE: Project CANOE may require a youth applicant to visit a doctor or specialist to confirm fitness and health are appropriate for our program, or to provide more detailed medical information. Please answer these questions thoroughly. Use extra pages if required.

Medications

1. List exact name of each medication, dosage and schedule, and how often used if "as required." Include puffers, birth control pills, and over-the-counter medications.

Name Of Medication	Dosage	Frequency of Dosage	Notes

Allergies

2. Please list all of the youth applicant's allergies. (i.e. Environmental, medication, food/nut, bee sting, etc.)

Type of Allergy	Severity of Reaction	Action / Meds Required
Food:	<input type="checkbox"/> n/a	
Insect:	<input type="checkbox"/> n/a	
Drug:	<input type="checkbox"/> n/a	
Environmental:	<input type="checkbox"/> n/a	
Other:	<input type="checkbox"/> n/a	

NOTE: It is your responsibility to indicate if there is a danger of an anaphylaxis reaction associated with an allergy.

3. Ever experienced breathing problems or swelling with an allergic reaction?

Yes No

4. Ever had an allergic reaction to Advil, Ibuprofen, anti-inflammatory medication or steroid?

Yes No

5. Has the youth applicant ever been prescribed an "epi-pen"?

Yes No

Surgeries / Hospitalization

6. Please list ALL the youth applicant's surgeries or hospitalizations.

Date	Type of Surgery or Reason for Hospitalization

Breathing

7. Does the youth applicant have asthma?

Yes No

If YES, is the asthma...

Mild

Moderate

Severe

8. Any other breathing or lung problems?

Yes No

If YES, describe.

9. Any limitations on activity?

Yes No

If YES, describe.

NOTE: Please be sure to list ALL youth applicant's puffers and dosage/schedule in Question #1 above.

Name:

Part D. Letter to doctor.

Dear Doctor,

This youth has applied to come on a Project C.A.N.O.E. trip. We are a registered non-profit organization. Our program includes moderately strenuous canoe trips, as well as other activities such as rock climbing, snow shoeing and dog sledding, etc. These activities can present a challenging psychosocial environment for our youth. Furthermore, a youth can be up to 3 days away from medical facilities. Overall, our youth get excellent benefits. Please help us review the applicant's fitness.

Our youth are often from financially difficult backgrounds. If it is at all possible, we, therefore, ask to please waive any of the usual fees, or at least keep them to a minimum. Unfortunately, the fees charged for a simple medical form is enough to prevent many youth from accessing our programs. It is possible to bill an A007A along with a K005A in order to compensate you for your assistance. We hope the form completed by the applicant and his/her parent guardian will be efficient and self-explanatory.

Thank you.

Sincerely,
Dr. Tushar Mehta MD CCFP
Medical Director, Project CANOE

Name:

Part D, continued. Doctor's review and signature.

Instructions to Doctor.

Please review Part C, the medical form completed by the youth and the parent/guardian/worker, and do any focused physical examination that you feel is necessary. Then answer the following:

1. I am a physician who the applicant sees on a regular basis.	<input type="checkbox"/> Yes <input type="checkbox"/> No
If NO, how long have you known the youth?	
2. The form filled out by the applicant and parent seems accurate and complete overall.	<input type="checkbox"/> Yes <input type="checkbox"/> No
If NO, please explain what may be missing.	
3. Please note any relevant findings on history and physical exam.	
4. To my knowledge, I feel that the applicant is fit to go on a Project C.A.N.O.E. trip., from a medical and psychiatric viewpoint. There are no contraindications.	<input type="checkbox"/> Yes <input type="checkbox"/> No
If NO, please explain your concerns.	
5. Before being approved for a Project CANOE trip, I feel that further work up is necessary the following issues:	<input type="checkbox"/> Yes <input type="checkbox"/> No
List any issues or concerns below. Please emphasize those you feel are very serious or prohibitive.	
6. List any comments or advice that we should follow for the applicant, if he/she is approved for our program.	

Doctor Signature

Date

Note: This review of fitness is valid within Project C.A.N.O.E.'S programs for one year.

Parent/Guardian/Worker: Did you have to pay for this doctors review?

Yes No

If YES, how much did it cost?

\$