PARTICIPANT INFORMATION FORM

Please print - This form is to be completed and must be signed by the participant's parent or legal guardian if under the age of 18. Please be **very specific** with all information so that the staff is fully informed. Feel free to include extra explanation sheets.

Legal Name:		**DOB**: M: D: Y:
Preferred Name:		**Pref. Gender ID**:
Address:		
City:	Prov:	Postal Code:
Youth Email:		Instagram:
Are you on Facebook or Instagram? □ F.B. □ Instagram **Find Us** on **Facebook:** Anglican Family Hub **Instagram:** Niagara_anglican_cyfm **Follow us to see posts and YM updates!**		Youth Cell #: ( )
Parish (include city/town):		

Parent Name:	**Parent Name:**
Home Phone: ( )	Home Phone: ( )
Work/Cell Phone: ( )	Work/Cell Phone: ( )
Email:	Email:
Family Physician's Name:	**Alternate Contact:**
Physician's Phone: ( )	Alternate Contact Phone: ( )
Health Card #:	**Relationship to Participant:**

Are there any special dietary requirements?	□ Yes □ No □ Specify:
Vegetarian:	□ No □ No: but no red meat □ Vegan □ Yes: but will eat: chicken □ fish □ eggs □ dairy □
Are all the participant's vaccines up to date?	□ Yes □ No □ Specify:
Have you received two COVID-19 vaccinations?	□ Yes □ No □ Specify:
For a headache, what would you give?	□ Tylenol □ Advil □ Other *(specify)*:

LEARNING

Are there any adaptations, accommodations or Individualized Education Plans in place that make for a better learning environment for the participant? If so, please describe so we can ensure the best possible learning experience.

_____

_____

_____

ALLERGIES (please list reactions)

□ To the following foods:_____

□ To medications:_____

□ To bees, wasps, hornet stings □ Other allergies:_____

Please describe severity and reactions (e.g. life-threatening, breathing problems)_____

_____

Treatment (e.g. Benadryl, injection; dosage & times given):_____

Needs Epipen® kit: Yes □ No □ *Participants must carry their own personal Epipen®.*

MEDICATIONS:

	Name of medication:	Dosage & Frequency:	Reason for use:
e.g.	Vitamin C (500mg)	1 pill at 8:30 a.m.	Fight off scurvy & nutritional supplement
1			
2			
3			

*if more room is required please feel free to attach an additional sheet

Other side…

HEALTH HISTORY *You may attach additional pages if needed*

Please provide information to expand our ability to care for the participant. Describe any illnesses (e.g. Epilepsy, Fainting Spells, Migraine/Headaches, etc.) or conditions that would be important for our staff to know about and how these conditions are dealt with at home. Please share with us any changes at home that might impact her/his participation (e.g. a death, separation or divorce, or any other traumatic experience).

i. The parent(s) or guardian(s) submitting this application are those having legal custody of the participant. Conditions of custody and access, if applicable, should be communicated in writing to the Program Department.

ii. I consent to my child's participation in the activities associated with the program unless a physician's note has been written to excuse her/him or further information has been noted on the health form.

iii. Program Staff reserves the right to dismiss a participant who has displayed unacceptable behaviour, and/or has not complied with the norms of the event, or for medical reasons.

iv. The parent(s) or guardian(s) agree to hold harmless the Diocese of Niagara, its employees, and volunteer staff from any cost or liability in connection with the injury, death or damage to any person or property during this event.

v. In the case of medical or surgical emergency, I understand every effort will be made to contact parent(s) or guardian(s). In the event I cannot be reached, I hereby authorize and consent to Diocese of Niagara, its employees, and volunteer staff to obtain medical assistance including first aid, treatments, transport, hospitalization, blood transfusion and/or anaesthesia or surgery if required. I give permission to contact this participant's personal physician for clarification of medical treatment.

vi. I agree to release Diocese of Niagara, its employees, and volunteer staff from any cost or liability arising out of the performance of any medical procedure in relation to such medical assistance.

vii. Each participant must be covered by provincial or equivalent health insurance. I hereby assume full responsibility for any extra expenses required for the treatment of the participant that is not covered by Ontario Hospital Insurance or equivalent health insurance.

viii. I have read and singed the photo/video release form.

ix. I have read and signed the COVID-19 waiver release form.

x. The Diocese of Niagara is committed to protecting the confidentiality, privacy and accuracy of personal information it collects. The information gathered in this form will be used solely to support the participant's involvement with the Diocese of Niagara and will not be disclosed to a third party except in a medical emergency.

Signature of Participant _____ **Signature** of Parent/Guardian (if under 18 yrs) _____ Date _____

Please sign and return this form to: Sarah Bird
Diocese of Niagara, 252 James St. N., Hamilton, ON L8R 2L3
or scan and e-mail to sarah.bird@niagaraanglican.ca

Event Use Only: *Treatment notes to be completed by staff person dispensing meds or first aid*

DATE	TIME	REASON	TREATMENT	STAFF