Information Sheet

IN CASE OF EMERGENCY CALL 9-1-1

Contact Information

First Name:_____ Last Name: _____

Address: _____ Apartment/Unit Number: _____

City: _____ Postal Code: ___ ___ ___ ___ ___ ____

Main Phone: (___ ___ ___) ___ ___ ___-___ ___ ___ ___Alt. Phone: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

Health Card: _____ Birth Date: _____/_____/_____
Year Month Day

Primary Language(s): _____ Gender: Male ☐ Female ☐

Emergency Contacts

Doctor/Family Physician: _____

Main Phone: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

Emergency Contact 1: _____

Main Phone: (___ ___ ___) ___ ___ ___-___ ___ ___ ___Alt. Phone: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

Emergency Contact 2: _____

Main Phone: (___ ___ ___) ___ ___ ___-___ ___ ___ ___Alt. Phone: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

Relevant Medical History

☐Cardiac (angina, heart attack, bypass, pacemaker ☐Diabetic (insulin/non insulin dependant) ☐Cancer

☐Stroke/TIA ☐COPD (emphysema, bronchitis) ☐Alzheimer

☐Hypertension (high blood pressure) ☐Seizure (convulsions) ☐Dementia

☐Congestive heart failure ☐Asthma ☐Psychiatric

☐OTHER: _____