



Kamloops Canoe and Kayak Club

Shumway lake
Kamloops, British Columbia, Canada
www.kamloopscanoeandkayak.com

Name _____

Address _____

City _____ Postal Code _____

Contact number (work) _____ (home) _____

Email _____

Birth Date _____ Male Female

Please check one:

- Drop In** (one time use only) **\$10.00**
- School Groups** **\$15.00** per student.
- Summer Camp** **\$135.00** includes club membership!
- 2nd Camp week** **\$75.00** must be a consecutive camp.
- Annual Club Membership** **\$135.00** CanoeKayak BC Membership required for racing (Visit <http://www.canoeandkayakbc.ca/admin.html> for the form).
- Officials Membership** **\$5.00** Level achieved () Date ()
- Coaches Membership** **\$20.00** NCCP # ()

Visit <http://www.kamloopscanoeandkayak.com> to learn more about our programs and practice times.

Release of liability and disclaimer. The undersigned is familiar with the hazards of water sports and the activities of Kamloops Canoe & Kayak Club, and assumes all risks and liabilities thereof. In consideration of the understanding being permitted to participate in the activities of KCKC, a member of the Pacific Division of Canoe Kayak Canada, the undersigned does hereby for himself/herself, his/her heirs, executors, administrators and successors, release and forever discharge representatives, agents, directors, officials, servants, officers and members from any and all actions, claims or demands by reason of any personal injury, property damage or loss to himself/herself or his/her property arising from the operation of KCKC.

I agree that pictures taken by the club may be used for promotional purposes.

Name of participant _____ **Date** _____

Signature (parent/guardian if under 18 years) _____

How did you learn about our club and it's programs? _____

MEDICAL HISTORY FORM

Name _____

Address _____

City _____ Postal Code _____

In Case of Emergency
Please Notify: _____

Contact number (work) _____ (home) _____

Correct Provincial Medicare number must be provided:

Medical Insurance No. _____

Birth Date (M/D/Y): _____ Male Female

Blood Group & Type: _____ Height: _____ Weight: _____

Family Physician: _____ Phone: _____

Date completed: _____ Date Updated: _____

Signature (parent/guardian if under 18 years) _____

PAST HISTORY OR ILLNESS, HAVE YOU EVER HAD OR DO YOU NOW HAVE:

	YES	NO		YES	NO
HEAD INJURY	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD TRANSFUSIONS	<input type="checkbox"/>	<input type="checkbox"/>
NECK/BACK DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>
FAINTING SPELLS	<input type="checkbox"/>	<input type="checkbox"/>	THYROID DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHIATRIC DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES (SPECIFY)	<input type="checkbox"/>	<input type="checkbox"/>
EYE PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	_____		
GLASSES/CONTACTS	<input type="checkbox"/>	<input type="checkbox"/>	FRACTURES (SPECIFY)	<input type="checkbox"/>	<input type="checkbox"/>
NOSE BLEEDS	<input type="checkbox"/>	<input type="checkbox"/>	_____		
DENTAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	OPERATIONS (SPECIFY)	<input type="checkbox"/>	<input type="checkbox"/>
DEAFNESS/EAR PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	_____		
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	RECENT WITHIN ONE YEAR:		
BRONCHITIS	<input type="checkbox"/>	<input type="checkbox"/>	INFECTIOUS DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	HEAD INJURY	<input type="checkbox"/>	<input type="checkbox"/>
HEART PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	MAJOR SURGERY	<input type="checkbox"/>	<input type="checkbox"/>
ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	OVERUSE INJURY	<input type="checkbox"/>	<input type="checkbox"/>
BOWEL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	TRAMATIC INJURY	<input type="checkbox"/>	<input type="checkbox"/>
URINARY INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>			
KIDNEY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>			
MENSTRUAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>			
EATING DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>			

Date completed: _____ Date Updated: _____

Signature (parent/guardian if under 18 years) _____

NOTE: MEDICAL INFORMATION IS CONFIDENTIAL AND WILL BE KEPT ON SITE FOR EMERGENCY USE ONLY