COLUMBIAN SQUIRES ONTARIO PROVINCIAL BOARD

PHYSICAL FITNESS CERTIFICATE

THIS FORM IS TO BE FILLED OUT BY THE PARENT / GUARDIAN OF COLUMBIAN SQUIRE

Surname:_____ Given Name:_____ Initial: _____

Date of Birth:_____ Current Age:_____ Home Phone: ( ) _____

Address:_____ City:_____ Postal Code: _Physician's

Name:_____ Phone Number ( ) _____

O.H.I.P. Number:_____ Additional Insurance Coverage Held: _____

Squires Circle Name & Number: _____

EMERGENCY MEDICAL INFORMATION:

Does the Participant Have Any Allergies: ☐ Yes ☐ No?

☐ Medicine ☐ Insect Bites ☐ Toxins ☐ Food ☐ Smoke ☐ Plants ☐ Animals ☐ Other

Details: _____

_____

PARTICIPANT HAS HAD, PLEASE CHECK [X]

☐ Appendicitis ☐ Mumps ☐ Chicken Pox ☐ Measles ☐ Kidney Disease ☐ Scarlet Fever

☐ Rheumatic Fever ☐ Heart Condition ☐ Other: _____

IF SUBJECT TO ANY OF THE FOLLOWING, PLEASE CHECK [X] AND GIVE DETAILS:

☐ Asthma ☐ Contact Lenses ☐ Headaches ☐ Fainting Spells ☐ Bleeding Disorders ☐ Cramps

☐ Ear Problems ☐ Diabetes ☐ Hernia ☐ Back Problems ☐ Motion Sickness ☐ Bed Wetting

☐ Convulsions ☐ Sleepwalking ☐ Nightmares ☐ Other

Details: _____

_____

DOES THE PARTICIPANT REQUIRE SPECIAL CARE, MEDICATION OR DIET (For Medication please advise name of medication, dose, frequency of dose)

Details: _____

DATE OF MOST RECENT PHYSICAL EXAMINATION (Month and Year) : ____

_____ **DATE OF**

LAST TETANUS SHOT (Month and Year) : ____ ☐ ____ ☐ ____

HAS IT EVER BEEN NECESSARY TO RESTRICT THE PARTICIPANT'S ACTIVITIES FOR MEDICAL REASONS Yes No

Details: _____

If there any changes to Squires health of any kind, the State Squires Director must be informed in writing immediately. This form covers the Fraternal Year

SIGNATURE, PARENT / GUARDIAN:_____ **DATE:** _____