MEDICAL INFORMATION FORM

☐ Female
☐ Male

Date of Birth: Day_________ Month ________________________ Year _________________
Address: ____
Postal Code: ________________________ Telephone #: ________________________________
Manitoba Health Number: _________________________(6 digits)
Personal Health Identification Number: ___________________________________(9 digits)
Name of Caregiver 1: ____
Home Ph.#: _____________________ Work Ph #: ____________________
Name of Caregiver 2: ____
Home Ph.#: _____________________ Work Ph #: ____________________

Family Physician: ____
Phone #: ___________________________________

Any Health Concerns:

☐ YES __NO

If yes, please give details:

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____
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________________.

Person to contact in case of emergency, if Parent/Guardian is not available:

Name: ____
Telephone #: ____
Address: ____