5MD Inc.

MEDICAL INFORMATION SHEET

Full Name: _____

Date of birth: Day _____ Month _____ Year _____

Sex: ___

Hire Date: _____

Address: _____

Telephone: (____) _____ Cell: (____) _____

Provincial Health Number (optional): _____

Alternate emergency contact (If available)

Name: _____

Relationship: _____

Telephone: (____) _____ Cell: (____) _____

Doctor's Name: _____

Telephone: (_____) _____

Date of last complete physical examination: _____

Please check the appropriate response and provide details below if you answer "Yes" to any of the questions.

Yes ❑ No ❑ Medication

Yes ❑ No ❑ Allergies

Yes ❑ No ❑ Previous history of concussions

Yes ❑ No ❑ Fainting or seizure during or after physical activity

Yes ❑ No ❑ Near fainting or Brownouts

Yes ❑ No ❑ Seizures and/or epilepsy

Yes ❑ No ❑ Wears glasses

Yes ❑ No ❑ Are lenses shatterproof

Yes ❑ No ❑ Wears contact lenses

Yes ❑ No ❑ Wears dental appliance

Yes ❑ No ❑ Hearing problem

Yes ❑ No ❑ Asthma

Yes ❑ No ❑ Trouble breathing during exercise

Yes ❑ No ❑ Heart Condition

Yes ❑ No ❑ Palpitations or Racing Heart

Yes ❑ No ❑ Family history of heart disease

Yes ❑ No ❑ Family history of unexpected death during physical activity

Yes ❑ No ❑ Family history of unexplained death of a young person

Yes ❑ No ❑ Diabetes – Type 1_____ Type 2_____

Yes ❑ No ❑ Wears medical information bracelet/necklace
For what purpose? _____

Yes ❑ No ❑ Health problem that would interfere with participation on any projects

Yes ❑ No ❑ Has had an illness that lasted more than a week and required medical attention in the past year

Yes ❑ No ❑ Has had injuries requiring medical attention in the past year

Yes ❑ No ❑ Been admitted to hospital in the last year

Yes ❑ No ❑ Surgery in the last year

Yes ❑ No ❑ Presently injured
Injured body part: _____

Yes ❑ No ❑ Vaccinations up to date
Date of last Tetanus Shot:_____

Yes ❑ No ❑ Hepatitis B vaccination

Yes ❑ No ❑ Covid-19

Please give details if you answered "Yes" to any of the above. (Use separate sheet if necessary)

_____

_____

_____

Medications:_____

Allergies: _____

Medical conditions: _____

Recent injuries: _____

Any information not covered above: _____

_____

I understand that it is my responsibility to keep 5MD Inc. advised of any change in the above information as soon as possible. I also authorize release of information to appropriate people (Physician) as deemed necessary. Physicians may release patient information to lawyers and other parties when requested to do so only if the patient or the patient's substitute decision-maker has given authorization, preferably in writing, or if authorized by law or a court order.

Date: _____ Employee Signature: _____

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