

ACFC HEALTH FORM

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____

SASKATCHEWAN HEALTH SERVICES NUMBER _____

NAME & PHONE # OF FAMILY DOCTOR _____

NAME & PHONE # OF FAMILY DENTIST _____

PARENTS' NAMES _____

ADDRESS _____

EMERGENCY PHONE NUMBERS:

NAME(S) _____

HOME _____ WORK _____ CELL(S) _____

DO YOU HAVE ANY ALLERGIES? ARE YOU CURRENTLY TAKING ANY
MEDICATION? DO YOU CARRY AN EPI KIT? Please explain

DO YOU HAVE ANY FOOD ALLERGIES? Please give details

DO YOU SUFFER FROM ASTHMA? _____

DO YOU USE AND CARRY AN INHALER _____ Please explain

If there are special needs or circumstances of which we should be aware please outline below.
