



**NICK CARDONE RCT-C, CCC, M.ED.
COUNSELLING, PSYCHOTHERAPY, ADVENTURE
THERAPY
902-456-3613**

Health Form

Name _____ Date of Birth _____
Home Address _____ Home Phone _____
Town _____ Postal Code _____ Email address _____
Doctor's Name _____ Health Card No. _____
Doctor's Phone _____ Expiry Date _____

IN CASE OF EMERGENCY

*** Please name a person who will be available for contact during the program in the case of emergency.**

Name _____ Relationship _____
Home Phone _____ Other Phone _____

Health Information

1. Please list all allergies to medications, food, insect stings, grass, animal, etc.

***NOTE:** Please bring an Epi-pen if you have a known anaphylactic allergy.

➤ **Medications/Penicillin:**

Reaction:

Treatment:

➤ **Food:**

Reaction:

Treatment:

➤ **Insect stings:**

Reaction:

Treatment:

➤ **Other:**

Reaction:

Treatment:

2. Please list any medications you are currently taking.

***NOTE:** If necessary, please bring 2 inhalers or 2 courses of insulin.

Medication (s):

Reason:

Dosage:

Side effects:



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3. Please indicate & describe any chronic health care conditions of which we should be aware.

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Chronic Congestive Heart Failure |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Stroke/Cva |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker Or Similar Device |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Any Restricted Activities (please list) _____ | <input type="checkbox"/> Asthma |
| _____ | <input type="checkbox"/> Breathing Difficulties (Chronic cough,
shortness of breath, bronchitis, asthma,
emphysema) |
| _____ | |

=====

Photograph/Video Consent

Permission is granted for T.O.N.E. Project Facilitators to use still photographs or video footage of this participant in promotional and educational publications and/or materials.

YES _____ NO _____ [please check one]

Participant Signature

Date



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Release of Liability

I understand that during my participation in the program for which I have applied, I may be exposed to situations and environmental conditions where the stresses and hazards may be greater or different than those I normally encounter. I understand, too, that although the T.O.N.E. Project Facilitators has taken precautions to provide proper organization, supervision, instruction and equipment for all activities, circumstances may arise which are not foreseeable or which are beyond the control of the T.O.N.E. Project Facilitators. I acknowledge that the T.O.N.E. Project Facilitators cannot guarantee absolute safety. I also understand that I am, in part, responsible for my own safety and I agree to comply with the instructions and directions of the T.O.N.E. Project Facilitators during the program.

I agree to assume all of the risk arising out of my participation in the program. This includes, but is not limited to, any risks that are unforeseeable.

I have accepted responsibility to verify that I do not have any physical or psychological problems which would create undue risk to myself or others who may depend on me during the program. In this regard, I have completed the Confidential Medical History and I acknowledge that the T.O.N.E. Project Facilitators will rely upon statements as to my medical condition contained therein and herein.

I HAVE READ AND UNDERSTAND THIS FORM AND ACKNOWLEDGE THAT IT IS A CONDITION OF BEING ACCEPTED IN THIS PROGRAM, THAT I AGREE TO THE TERMS OF THIS ACKNOWLEDGEMENT AND ASSUMPTION OF RISK.

To the best of my knowledge, I am in good physical condition (except as noted previously) and capable of participating in an active outdoor and adventure therapy program. Authority is granted for me to be given emergency medical treatment as deemed appropriate.

(In the event of an emergency, your contact person will be contacted immediately!)

Participant Signature

Date