Medical Card

Name of Client: _____

D.O.B.: _____ / _____ / _____ **Health Card #:** _____
DD MM YY

Client's Address: _____

Phone #: _____ **Alt. Phone #:** _____

Height: _____ **Weight:** _____ **Sex:** ☐ M ☐ F

Hair Colour: _____ **Eye Colour:** _____

Distinguishing Features: _____

_____

SEE: Client's Current *Psychotropic Medication Consent Form*

Allergic Reactions: _____

Most Recent Tetanus: _____

Special Medical Needs: _____

Family Doctor: _____ **Phone #:** _____

Legal Guardian: _____ **Relationship:** _____

Address: _____

Home Phone #: _____ **Alt. Phone #:** _____

In the event the Legal Guardian cannot be reached, please contact:

Name: _____ **Phone #:** _____

In the event of an emergency or when time or circumstances prohibit contact of the Legal Guardian, I, the undersigned, authorize the Executive Director of Woodview Mental Health & Autism Services, and her designates, to arrange medical and surgical care including general consent for hospitalization and the administration of anesthetics when it is deemed necessary. I also authorize Woodview staff to administer first aid treatment when necessary.

Authorized by: _____ **Date:** _____
(Legal Guardian)

Witness: _____ **Date:** _____

Authorized by: _____ **Date:** _____
(Client over 12 years)

Witness: _____ **Date:** _____

☐ Verbal consent received from client/guardian indicated above.