Office use only: Date Paid_______________

Campbell River Beacon Club Membership Form

Name____

Street Address____

City______________________________ Postal Code_________________________

Home phone_________________________ Cell__________________________

Email____

Birth date_____________________

Do you want your birthday posted on the monthly birthday poster in the kitchen? Y__N__

Contact Person____________________________ Relationship to you______________

Phone #(s)____

Mental Health Diagnosis: *Please check all that apply to you.*

- ☐ Anxiety
- ☐ Bi Polar
- ☐ Depression
- ☐ Obsessive Compulsive Disorder (OCD)
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Schizoaffective Disorder
- ☐ Schizophrenia
- ☐ Other (please list):____

Do you have any allergies we should know about? (food, pets, etc)

____

Care Card # (PHN – Personal Health Number):________________________________

Doctor(s)____

Mental Health worker(s)____

Please list all medications you are currently taking (and their dosages), including those prescribed by your doctor and/or psychiatrist, over the counter drugs (e.g. for allergies or heartburn) and/or vitamins and supplements. Attach extra page(s) if necessary.

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