

Camp Menesetung 2011



Camper Health Form

The use, retention and disclosure of personal information collected from this form is done in compliance with privacy legislation including, but not limited to, the Personal Information Protection and Electronic Documents Act (2000, c.5).

Health Center Use Only

Camp #: _____

Cabin: _____

CAMPER'S NAME: _____

Date of Birth (dd/mm/yy) _____ / _____ / _____

Gender _____ **Age** _____ **Height** _____ **Weight** _____

Health Card Number: _____

Private Insurance Carrier: _____ **Group #:** _____

Parents/Guardians: _____

Address: _____ **City:** _____

Postal Code: _____

Telephone Home: (____) _____ **Work:** (____) _____

Alternate Emergency Contact (if parents/guardians cannot be reached):

Name: _____ **Relationship to camper:** _____

Address: _____ **City:** _____

Telephone Home: (____) _____ **Work:** (____) _____

Family Physician's Name: _____

Address: _____ **City:** _____

Telephone: (____) _____

Please check if the camper has/had any of the following:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ear Troubles | <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Seizure Disorders |
| <input type="checkbox"/> Toothaches | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Red Measles | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> ADD/ADHD | |

Please explain any information about special conditions: _____

Special Diets:

_____ None _____ Lactose Intolerate _____ Celiac

_____ Vegan (no meat or dairy products)

_____ Partial Vegetarian: _____ eats dairy _____ eats eggs _____ eats chicken

For Female Campers:

Has she menstruated? _____ Has she been informed about menstruation? _____

(OVER)

VACCINATIONS:

Child Series (age 0-4yrs)	Yes	No	Meningococcal Disease	Yes	No
Chicken Pox	Yes	No	Hepatitis B	Yes	No
Date of last booster: _____			(Year)		

DOES YOUR CHILD HAVE ANY KNOWN ALLERGIES? YES NO

ALLERGY TO:

DRUGS: _____ Describe reaction and treatment: _____

INSECT STINGS: _____ Describe reaction and treatment: _____

FOOD: _____ Describe reaction and treatment: _____

OTHER: _____ Describe reaction and treatment: _____

NOTE: TO CARE FOR YOUR CAMPER TO THE BEST OF OUR ABILITY, PLEASE DESCRIBE ANY OTHER PHYSICAL, EMOTIONAL OR BEHAVIORAL PROBLEMS: _____

Please describe medications or treatments required:

Treatment or Medication (Purpose)	Dosage	Time(s) of Day Required

*****Please Note:** To comply with insurance regulations **all** medications (prescription and over the counter) must be given to the nurse/first aider *in original bottles* at registration.

To the best of my knowledge my child is in good health. I will notify the camp if he or she has been exposed to an infectious disease during **three weeks** prior to arriving at camp.

**** I will also notify the camp *in writing* if my child has any changes in his/her medical condition between the time I send in this Camper Health Form and the Opening Day of the camp session.**

I hereby agree to permit my child to participate in the full range of Camp activities (unless I advise you in writing) and authorize the Camp Director and/or his/her appointee of staff to follow the physician approved medical directives, and in the event of accident, injury or illness affecting the above named camper, to authorize on my behalf all medical and other procedures, including admission to hospital and all other necessary treatment, as he/she may deem essential for the care and well-being of the said camper. Such action is to be taken only when immediate contact with the undersigned cannot be made. Please insert any conditions/limitations that would prevent your child from taking part in any camp activities: _____

_____ I agree that, having taken such precautions as in your discretion are deemed advisable, you shall not be held responsible for any accident or sickness to my child.

Parent's/Guardian's Signature: _____

Date: _____

EVERY EFFORT WILL BE MADE TO NOTIFY THE PARENTS/GUARDIANS IF THERE IS ANY SITUATION REQUIRING THE DOCTOR'S ATTENTION AT THE ABOVE LISTED NUMBERS.

**Please return by mail along with the Camper Information Form to the Registrar:
Marg Bakker, RR#3 Auburn, ON N0M 1E0**