



## Health Information Form

The information on this form will be used at the discretion of the camp health care staff to ensure care and attention is given to the health of the participant. All information is considered personal and confidential.

Name \_\_\_\_\_ Birth Date: \_\_\_\_\_  
(Family Name) (Given Name) (ddmmyy)

Parent/Guardian Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Province: \_\_\_\_\_ Post Code: \_\_\_\_\_

Parent/Guardian 1

Phone : Home \_\_\_\_\_ Business: \_\_\_\_\_ Cell: \_\_\_\_\_

Address (if different from above)

\_\_\_\_\_

Parent/Guardian 2

Phone : Home \_\_\_\_\_ Business: \_\_\_\_\_ Cell: \_\_\_\_\_

Address (if different from above)

\_\_\_\_\_

If the above is unavailable in an emergency, please notify:

1. \_\_\_\_\_

(Last Name) (First Name) (Relationship)

Phone : Home \_\_\_\_\_ Business: \_\_\_\_\_ Cell: \_\_\_\_\_

Address (if different from above)

\_\_\_\_\_

2. \_\_\_\_\_

(Last Name) (First Name) (Relationship)

Phone : Home \_\_\_\_\_ Business: \_\_\_\_\_ Cell: \_\_\_\_\_

Address (if different from above)

\_\_\_\_\_

Provincial Health Ins. No. \_\_\_\_\_

Other Ins. Carrier: \_\_\_\_\_ # \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

The camp program may include swimming, hiking, boating, and other physical activities.

Does the applicant suffer from any physical or emotional disorder that would prevent him or her from participating fully in this program? \_\_\_\_\_

If so, please state full particulars:

\_\_\_\_\_

Do you have any special instructions for camp staff regarding the applicant's health care or diet?

\_\_\_\_\_

(attach separate sheet if necessary)

Does the applicant have **allergic reactions** to such things as drugs, food, insect stings? If so, list, giving type of reaction and treatment given.

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Is the applicant currently subject to any of the following?

\_\_\_ Arthritis \_\_\_ Convulsions \_\_\_ Motion sickness \_\_\_ Respiratory ailments \_\_\_ Ear trouble  
\_\_\_ Nightmares \_\_\_ Bet wetting \_\_\_ Headaches \_\_\_ Sleepwalking \_\_\_ Other (please indicate)

Please give details of usual treatment should condition occur:

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Chronic conditions or recent illnesses of which staff should be aware:

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Please list any medication which the applicant is bringing to camp. This must be clearly labeled with name and circumstances under the medication is administered to the camper, and given to the camp health care staff on arrival at camp.

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On occasion, campers become ill at camp and require attention from our camp health care staff. Please indicate the non-prescription medication that the camp health care staff can administer to your child.

- |   |   |   |  |  |
|---|---|---|--|--|
| <input type="checkbox"/> Acetaminophen<br>(eg. Tylenol) | <input type="checkbox"/> Ibuprofen (eg. Advil)    | <input type="checkbox"/> Pseudoephedrine<br>(eg. Sudafed: Nasal Decongestant) | <input type="checkbox"/> Dextromethorphan<br>(eg. Sudafed: Cough and Cold) | <input type="checkbox"/> Cough Suppressant<br>(eg. Halls)  |
| <input type="checkbox"/> Child strength acetaminophen   | <input type="checkbox"/> Child Strength ibuprofen | <input type="checkbox"/> Child Strength Pseudoephedrine                       | <input type="checkbox"/> Child Strength Dextromethorphan                   | <input type="checkbox"/> Brompheniramine<br>(eg. Dimetapp) |

Other Medication: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Are corrective lenses required? \_\_\_ Contact lenses? \_\_\_\_\_

Other comments or information not mentioned above:

N.B. EVERY CARE AND ATTENTION WILL BE GIVEN TO THE HEALTH AND COMFORT OF PARTICIPANTS

I hereby authorize \_\_\_\_\_ (name of camp) to secure such medical advice and services as may be deemed necessary for the health and safety of myself or my child (or ward).

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Signature of Applicant or  
Parent/Guardian if applicant is under 18

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Date