2016 Camper Health Form

Session code(s): _____

IMPORTANT: Health Form must be submitted to our camp office upon registration. Updates can be submitted later by email.
Please ensure it is filled out completely & accurately. Campers cannot attend camp without a current health form on file prior to camp.

CAMPER INFORMATION: *(print clearly)*

Submit completed health form by email or mail, do not fax.

Last Name: _____ First Name: _____ Middle Name: _____

Birthdate: (mm/dd/yyyy) _____ Camper's Age on July 1st, 2016: _____ Gender: ❒Male ❒Female

Household Address: _____

City/Town: _____ Province/State: _____

Country: _____ Postal/Zip Code: _____ Home Phone#: _____

PARENTS / GUARDIANS & EMERGENCY CONTACTS: *(print clearly)*

(attach separate sheet of paper if necessary)

Martial Status of camper's parents/guardians: ❒Single ❒Married ❒Separated ❒Divorced ❒Widowed ❒ Common Law ❒Other

Legal Custody: **who has Custody and is Legally Responsible** for this camper (be sure to include their contact information below):

❒Both Parents (live together) ❒Joint Custody (live apart) ❒Mother ❒Father ❒Grandparents ❒Guardian ❒Foster Parents

❒Other: _____

★★★ **List in order who should be contacted in case of emergency – be sure to include parents/guardians:** ★★★

1st Contact: ❒Mr. ❒Mrs. ❒Ms. ❒Miss ❒Dr.	**2nd Contact**: ❒Mr. ❒Mrs. ❒Ms. ❒Miss ❒Dr.	**3rd Contact**: ❒Mr. ❒Mrs. ❒Ms. ❒Miss ❒Dr.
First & Last Name:	First & Last Name:	First & Last Name:
Relationship:	Relationship:	Relationship:
Home Phone:	Home Phone:	Home Phone:
Work Phone:	Work Phone:	Work Phone:
Cell/Pager:	Cell/Pager:	Cell/Pager:
Summer #:	Summer #:	Summer #:

Camper's Health Card #: _____ Expiry Date: _____

A photo for emergency purposes will be taken on arrival day

Out-of-Canada campers: indicate any medical plan, numbers & billing address, (attach separate piece of paper if necessary)

Family Doctor: _____ Phone: _____

Family Dentist / Orthodontist: _____ Phone: _____

Immunization Dates: Chicken Pox: _____ Hepatitis B: _____ Meningitis: _____

Diphtheria/Pertussis/Tetanus/Polio: _____ MMR (Measles/Mumps/Rubella): _____

ALLERGIES: Does your child have any allergies. Be specific, attach separate page if necessary.

★ ***Please note, we do NOT use or allow foods/snacks that contain nuts or traces of nuts.*** ★

Indicate Type: Drug, Food, Environmental, Insect, Other	Allergen (please be specific)	Type & Severity of Reaction (Indicate if life-threatening)	Management / Treatment / Medication	Date of Last Reaction

EPI-PEN: Does your child require an EpiPen? ❒**No** ❒**Yes** - If yes, please provide details about your child's anaphylaxis, including the date and description of any reaction. You MUST fill out an **ANAPHYLAXIS EMERGENCY PLAN FORM** (available on our website) and bring this to camp on arrival day. _____

***** If your child is required to carry their EpiPen (i.e. bee/wasp allergy), please provide two non-expired EpiPens; one for your child to carry with them and one to keep in the Health Centre. *****

DIETARY RESTRICTIONS: ❒Vegetarian ❒Vegan ❒Lactose Intolerant ❒Gluten Free ❒Other: _____

2016 Camper Health Form (continued)

Last Name:_____ **First Name:**_____

ASTHMA/INHALER: Does your child have asthma? ❒**No** ❒**Yes** - If yes, indicate severity? ❒Mild ❒Moderate ❒Severe ❒Made worse by activity. What are the triggers for these attacks? _____

If your child will be carrying his/her puffer with them, please bring an extra non-expired puffer to be left in the Health Centre. If your child has used their puffer in the last year, they are required to have a puffer at camp.

MEDICATIONS AT CAMP: Will your child be taking any medications while at camp (prescription or homeopathic)?

If yes, list medication, dosage, schedule, route, and reason for medication: _____

***** ALL PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS MUST BE LEFT WITH THE HEALTH CARE STAFF WHILE AT CAMP ***. Prescription medication brought to camp must be in its original packaging and must be labeled with the doctor's name, child's name, dosage, schedule, route and date. A pharmacy issued blister pack is required if your child requires 3 or more daily medications. If any over-the-counter medications are sent to camp with your child, they must be in the original package and left with the Health Care Staff. *****

TREATMENTS: Will your child require any treatments while at camp? If yes, please explain:

MEDICATIONS AT HOME: Does your child regularly take any medications that will not be taken at camp?

OVER-THE-COUNTER MEDICINE AT CAMP:

May the following over-the-counter medications be given to your child while at camp, if deemed necessary by the nurse?

❒ Acetaminophen (Tylenol) ❒ Antacids ❒ Antihistamines **(**Benadryl) ❒Gravol ❒ Ibuprofen (Advil)

Is there anything the camp needs to be aware of when giving any of the approved over-the-counter medications to your child?

HEALTH HISTORY: **Has your child experienced or is currently experiencing any of the following conditions:**

___ADD/ADHD
___Athlete's Foot
___Back / Neck Pain or Injury
___Bedwetting
___Behavioral Issues
___Blackouts / Fainting
___Bleeding Disorder
___Chest Pain
___Chrons / Colitis / IBS
___Concussion
___Constipation / Diarrhea
___Dental Braces / Caps / Bridges
___Developmental Delays
___Diabetes
___Ear Infections / Hearing Problems
___Epilepsy / Seizures
___Fetal Alcohol Syndrome
___Headaches / Migraines
___Heart condition
___Hernia
___Homesickness
___Kidney Disease
___Learning Disabilities
___Menstrual Difficulties
___Mental Health Issues
___Motion Sickness
___Nightmares / Terrors
___Nosebleeds
___Sinus infections
___Skin Problems
___Sleepwalking
___Speech Problems
___Stomach aches
___Sprains, Strains, or Fractures
___Tonsillitis
___Urinary Tract Infection
___Visual Problems / Wears Glasses/Contacts
___Weight Concerns / Eating Disorder
___Other, please explain:

Be sure to fully explain any conditions your child is currently experiencing. It is important to include ALL information regarding your camper's history of illness so that our staff are prepared in case of incident or emergency.

2016 Camper Health Form (continued)

Last Name:_____ **First Name:**_____

OPERATIONS / HOSPITALIZATION / SERIOUS INJURY:

Has your child had any operations, ever been hospitalized, or had a serious injury. If yes, please explain giving details, date of occurrence, any lingering effects on child's health, and any signs of illness that camp staff should look out for._____

DISEASES: Has your child had any of the following diseases? If yes, please explain (date, details).

____Chicken Pox (Varicella) ____Hepatitis ____Measles ____Mononucleosis
____Mumps ____Rheumatic Fever ____Scarlet Fever ____Whooping Cough

ACTIVITY RESTRICTIONS: Camp Kawartha is located on a rugged, wooded site. Most of the activities take place outdoors.

All 2-week, 3-week, tripping and leadership programs go offsite for an overnight camping/canoe trip.

Does your child have any restrictions on activity? ❒**No** ❒**Yes** - If yes, please explain:_____

ADDITIONAL INFORMATION: Please list any other medical information the camp should know about your child.

Is there anything you would like to discuss with the camp medical staff?

IMPORTANT REMINDERS - please read carefully!

- I understand that all information collected will be used to diagnose, treat or maintain my child's physical or mental health and to assist in preventing disease or injury or to promote health. This information is considered to be confidential and will be shared amongst health care providers as needed; ie: Health Care Coordinator, Camp Nurse, Nurse's Assistant, Camp Physician, Walk in Clinic or Emergency Health Care Providers. This information will only be shared with the Camp Director and Camp staff on a need to know basis to ensure the physical and mental health of my child.
- To the best of my knowledge, my child is in good health. **I will notify the camp in writing prior to arrival if there is any change in my child's health, or he/she is exposed to any communicable disease within 3 weeks prior to arrival at camp.**
- In the case of a medical emergency, I understand that every effort will be made to contact parents or guardians. In the event I cannot be reached, I hereby give permission to the physician/nurse selected by the Camp Director to hospitalize, secure proper treatment, order injection, anesthesia or surgery for my child as named above.
- I agree to reimburse the camp for any prescriptions or medical expenses incurred for this camper.
- **I will do a head lice check on my child regularly and within 3 days before arriving at camp.** Campers found to have head lice on arrival will not be allowed to enter camp until the matter has been resolved. There will be no refund of camp fees.
- **I will submit any changes to this health form in writing to the camp prior to arrival**

★ Signature of Parent/Guardian:_____ Date:_____