

2012 Camper Health Form

Session code(s): _____

IMPORTANT: Health Form must be submitted to camp office by April 30th, 2012 or upon registration if after that date

Please ensure it is filled out completely and accurately. Campers cannot attend camp without a current health form and photo 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, 2012: _____ Gender: Male Female
 Camper's Home Address: _____
 City/Town: _____ Province/State: _____
 Country: _____ Postal/Zip Code: _____ Home Phone#: _____

PARENTS / GUARDIANS & EMERGENCY CONTACTS: *(print clearly)* *(attach separate sheet of paper if necessary)*

Marital 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: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> Dr.	2nd Contact: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> Dr.	3rd Contact: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> 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 #: _____ **Version Code:** _____

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

Family Doctor: _____ **Phone:** _____
Address: _____

Permission for our Camp Nurse/Doctor to contact your Family Doctor if necessary? Yes No

Immunization Dates: Tetanus: _____ Polio: _____
 Diphtheria: _____ Hepatitis B: _____
 Pertussis: _____ Meningitis: _____

**** All Campers ****

Attach current wallet-sized photo

(e.g. wallet or passport size photo, shows head/face & shoulders) will only be used to identify camper in case of emergency

Be sure to print full name on back of photo.

1. DIETARY INFO: Vegetarian Vegan Lactose Intolerant Gluten Free Other: _____

2. ALLERGIES: Be specific, attach separate page if necessary. *If camper uses an EpiPen, they must bring it to camp.*
****If your child has a life-threatening allergy you MUST fill out an "ANAPHYLAXIS EMERGENCY PLAN FORM" in addition to this health form.** (see our forms page: www.campkawartha.ca/summer-camp/preparing-for-camp.php)

★ 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

3. ASTHMA: Does your child suffer from asthma? No Yes If yes, indicate severity? Mild Moderate Severe
 What are the triggers for these attacks? _____

4. MEDICATIONS:
 Is camper currently on any medication (prescription or homeopathic)? If so, what? _____
 How and when is this medication administered? _____

2012 Camper Health Form (continued)

Last Name: _____ First Name: _____

MEDICATIONS:

All medications must be left with the health care staff while at camp. Prescription medications must be in their original container and must be labeled with the doctor's name, child's name, dosage, schedule, route and date. Over the counter medications must be in the original container with proper labeling.

5. OVER-THE-COUNTER MEDICINE:

Check (✓) if you approve the use of the following over-the-counter medicine that the camp has, for your child, if deemed necessary by the nurse? Tylenol (Acetaminophen), Advil (Ibuprofen), Gravol, cough medicine, cold medications, antihistamines

If NO, what would be an appropriate alternative? _____

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

Does your child have any physical, health, developmental, behavioral, or emotional condition that may affect his/her ability to participate in camp activities? No Yes - If yes, give details: _____

**All 2-week, 3-week, tripping and leadership programs go offsite for an overnight camping/canoe trip
*** Parents will be responsible for any charges/expenses incurred to Camp Kawartha if their child needs to be evacuated from an off-site trip, due to a medical or health condition, that was not disclosed prior to their child's attendance.**

7. HEALTH HISTORY:

<input type="checkbox"/> chicken pox	<input type="checkbox"/> epilepsy / seizures	<input type="checkbox"/> frequent stomach aches	<input type="checkbox"/> ear trouble	<input type="checkbox"/> bedwetting
<input type="checkbox"/> measles	<input type="checkbox"/> fainting / dizziness	<input type="checkbox"/> frequent headaches	<input type="checkbox"/> eye trouble	<input type="checkbox"/> nightmares
<input type="checkbox"/> mumps	<input type="checkbox"/> appendicitis	<input type="checkbox"/> migraines	<input type="checkbox"/> nosebleeds	<input type="checkbox"/> sleepwalking
<input type="checkbox"/> rheumatic fever	<input type="checkbox"/> tonsillitis	<input type="checkbox"/> sprains or strains	<input type="checkbox"/> toothaches	<input type="checkbox"/> other:
<input type="checkbox"/> whooping cough	<input type="checkbox"/> heart condition	<input type="checkbox"/> fractures	<input type="checkbox"/> frequent colds	
<input type="checkbox"/> hepatitis	<input type="checkbox"/> mononucleosis	<input type="checkbox"/> ADD / <input type="checkbox"/> ADHD	<input type="checkbox"/> sinus trouble	

If your child has or had any of the above, please give details. Does it affect their ability to participate in activities? If so, how?

8. RECENT hospitalization, operation, injury, serious illness, or infectious disease: If so, give date and details: _____

9. FEMALE CAMPERS: Has this girl menstruated? Yes No If not, has she been told about menstruation? Yes No

10. OTHER: please detail any other medical information of use to the Camp Physician or Camp Nurse:

IMPORTANT REMINDERS - please read carefully!

- To the best of my knowledge, my child is in good health. I will notify the camp 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 medical emergency, I understand 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 submit any changes to this health form in writing to the camp prior to arrival.
- **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.

★ **Signature of Parent/Guardian:** _____ **Date:** _____