

HEALTH FORM

CAMPER'S NAME _____ BIRTH DATE _____

PARENTS NAME _____ HOME PHONE (_____) _____

ADDRESS _____ OFFICE PHONE (_____) _____

EMERGENCY CONTACT _____ DAY PHONE(_____) _____ NIGHT(_____) _____

FAMILY DOCTOR _____ PHONE (_____) _____

O.H.I.P. NO.(ONTARIO) _____ OTHER INSURANCE _____

HEALTH HISTORY: GIVE DETAILS OF HOSPITAL ADMISSIONS, OPERATIONS, SERIOUS INJURIES AND CHRONIC ILLNESS:

ALLERGIES: _____

DISEASES: HAS YOUR CHILD HAD (GIVE DATES):

MUMPS _____ MEASLES _____ CHICKEN POX _____ OTHER _____

IMMUNIZATION HISTORY: (GIVE DATES):

DTP _____ BOOSTER _____ MMR _____ OTHER _____

ACTIVITIES TO BE RESTRICTED _____

HAS YOUR DAUGHTER MENSTRUATED? _____

MEDICATION TO BE TAKEN AT CAMP _____

IMPORTANT: PLEASE NOTIFY THE CAMP IF THIS CAMPER IS EXPOSED TO ANY COMMUNICABLE DISEASE DURING THE MONTH PRECEDING CAMP ATTENDANCE. ALL CAMPERS MUST BE CHECKED FOR LICE PRIOR TO ARRIVING AT CAMP. IF YOUR CHILD HAS LICE, BEGIN TREATMENT AND CONTACT US IMMEDIATELY.

IN THE EVENT I CANNOT BE REACHED IN AN EMERGENCY I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE CAMP DIRECTOR TO HOSPITALIZE, SECURE PROPER TREATMENT FOR, AND TO ORDER INJECTION, ANAESTHESIA OR SURGERY FOR MY CHILD.

SIGNATURE _____ DATE _____

TO BE COMPLETED BY PHYSICIAN: (NOT REQUIRED FOR ONTARIO RESIDENTS)
THE CAMPER NAMED ABOVE WISHES TO PARTICIPATE IN A STRENUOUS SUMMER CAMP PROGRAM WHICH INCLUDES ACTIVITIES SUCH AS SWIMMING, SAILING, CANOEING AND WILDERNESS CANOE TRIPS.

I HAVE EXAMINED THE CAMPER DESCRIBED AND HAVE REVIEWED HIS OR HER HEALTH HISTORY. IT IS MY OPINION THAT HE OR SHE IS PHYSICALLY ABLE TO ENGAGE IN CAMP ACTIVITIES WITHOUT RESTRICTION EXCEPT AS NOTED BELOW:

PHYSICIAN'S NAME (PLEASE PRINT) _____

ADDRESS _____

TELEPHONE (OFFICE) _____ EMERGENCY _____

SIGNATURE _____ DATE _____