CAMP NORTHWAY **HEALTH FORM** **CAMP WENDIGO**

CAMPER'S NAME________________________________BIRTH DATE________________________

PARENTS NAME________________________________HOME PHONE(___)___________________

ADDRESS_____________________________________OFFICE PHONE(___)__________________

____CELL 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:

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ALLERGIES:____

WILL YOUR CHILD BE BRINGING AN EPI-PEN TO CAMP?______________________

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____
Please advise if you are considering taking your child off any medication while 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: 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:

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PHYSICIAN'S NAME (PLEASE PRINT)____

ADDRESS____

TELEPHONE (OFFICE)_________________________EMERGENCY__________________________

SIGNATURE_______________________________________DATE__________________________