CAMP NORTHWAY CAMP WENDIGO HEALTH FORM

CAMPER NAME	
BIRTHDATE (YEAR/MONTH/DAY)	
CAMPER ADDRESS	
CAMPER OHIP NUMBER (Ontario)	
OTHER INSURANCE	
FAMILY DOCTOR NAME	
FAMILY DOCTOR PHONE	

PARENT 1 NAME	
CELL PHONE	
HOME PHONE	
WORK PHONE	
EMAIL	
ADDRESS	

PARENT 2 NAME	
CELL PHONE	
HOME PHONE	
WORK PHONE	
EMAIL	
ADDRESS	

EMERGENCY CONTACT 1 NAME	
CELL PHONE	
HOME PHONE	
EMAIL	
EMERGENCY CONTACT 2 NAME	
CELL PHONE	
HOME PHONE	
EMAIL	

HEALTH HISTORY:

If your child has had any hospital admissions, operations, serious injuries, or chronic illness, please give the details, date of occurrence, and any signs of illness we should be aware of:

_____

_____

_____

Has your child menstruated? _____

Has your child had (If yes, please give date, details):

Chicken Pox (Varicella)_____ Mumps_____ Measles_____

Mononucleosis_____ Whooping Cough_____ Other_____

_____

_____

Immunization History (Give Dates):

Chicken Pox_____ Meningitis_____

MMR (Measles/Mumps/Rubella) _____ COVID-19_____ (1st/2nd shot)

Diptheria/Pertussis/Tetanus/Polio_____

Please include vaccination record if available

Allergies: Does your child have any allergies foods, medicines, insects, environment? ☐Yes ☐No

NOTE: Camp Northway-Wendigo is **NOT a nut-free environment**

Will your child be bringing an EPI-PEN to camp? ☐Yes ☐No

If Yes, please send 2 non-expired EPI-Pens, 1 for your child to carry with them, and 1 to be stored at the Health Centre

Allergen	Type/Severity	Previous Reaction	Management/ Treatment/Medication

COVID-19 SYMPTOMS:
Common Symptoms of COVID-19 can be similar to those of allergies, or typical health conditions. Please help us to be aware of any symptoms your child may have from seasonal allergies, or pre-existing conditions:

Symptom	**Possible Causes**	**Check if present**
Cough or Barking Cough (Croup)	Asthma, or other known causes or conditions you already	☐
Shortness of Breath	Asthma, or other known causes or conditions	☐
Sore Throat or Difficulty Swallowing	Seasonal allergies, acid reflux, or other known causes or conditions	☐
Decrease/Loss of Taste or Smell	Seasonal allergies, neurological disorders, or other known causes or conditions	☐
Runny or Stuffy/Congested Nose	Seasonal allergies, being outside in cold weather, or other known causes or conditions	☐
Headache	Chronic migraines, tension headaches, or other known causes or conditions	☐
Extreme Tiredness/Muscle Aches	Thyroid dysfunction, depression, insomnia, sudden injury, or other known causes or conditions*	☐
Nausea, Vomiting and/or Diarrhea	Irritable bowel syndrome, anxiety, menstrual cramps, homesickness, or other known causes and conditions	☐

* *If you received a COVID-19 vaccination in the last 48 hours and are experiencing mild muscle aches/joint pain or mild fatigue that only began after vaccination, please do not check box*

Please provide details for any checked boxes:

_____

_____

Medications:

Does your child have asthma? ☐Yes ☐No

If yes, please indicate the severity: Mild ☐ Moderate ☐ Severe ☐

Made worse by activity ☐ Please indicate triggers_____

If your child will be carrying their puffer, please bring an extra non-expired puffer to be left in the Health Centre

Will your child be taking medications at camp? ? ☐Yes ☐No

Please list below:

Medication	Dosage Instructions	Comments

All medications, including over-the-counter, must be stored at the camp Health Centre, and are administered by the Health Centre staff.

Are there any medications you child normally takes that you will not be sending to camp?

☐Yes ☐No

If yes, please specify:

_____

IMPORTANT: Please notify the camp if your child is exposed to any communicable disease during the month preceding attendance.

All campers must be checked for lice prior to arriving at camp. If your child has lice, begin treatment, and contact us so we may continue treatment at camp.

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:

_____

PHYSICIAN'S NAME _____ (please print)

OFFICE PHONE _____ EMERGENCY PH_____

ADDRESS _____

_____

SIGNATURE _____ DATE_____