

HEALTH AND SAFETY

The Health Record

Camp Big Canoe requests parents to complete the accompanying Camp Health Form in order to give the health staff a detailed medical history of their child(ren). The more information you provide to us, the better we will be able to ensure a great camping experience for your child(ren). Health information may be shared with Camp staff (Director, cook, counsellors) on a “need-to-know” basis. Camp health care is given by a resident Registered Nurse, or a Registered Practical Nurse, and a local physician who is on call. If necessary, please attach to the health form a detailed note of any special medical, behavioural or dietary need of your camper. Please review the contents of the completed Health form with your camper and instruct him/her about the medications depending on age and maturity.

Special Note About the Health Record

There must be a new Health record for each camper each year, even if there has been no change in information. The immunization record must have the correct date beside each specific injection; in an emergency, it is very important for the physician to know exactly when the immunization was given.

Provincial Health Card

A photocopy, front and back, of the Provincial Health Card must be presented before healthcare will be given to any individual by physicians or the local hospitals. Please include this copy with the Health Record; the number alone is no longer acceptable.

Medic Alert Bracelets

The use of Medic Alert bracelets are advised for those campers with emergency type conditions.

Skin/ Eye Problems

Please check your child for such conditions as Athlete's foot, warts on feet, itchy rashes, pink eye (conjunctivitis) and, if required, have them cleared before coming to camp.

Head Lice

Please have head lice cleared up before the child comes to camp. If a camper is found to have head lice, the nurse will treat the condition with the over-the-counter product, NIX, following the instructions carefully. If there is any problem in clearing the condition, parents will be notified.

Sunblock and Insect Repellent

The use and application of sunblock and insect repellent should be explained and practised before camp.

SENDING MEDICATIONS TO CAMP

□ Please do not send over-the-counter (non-prescription) medications to camp. There is an appropriate stock of non-prescription medications in the Health Centre approved by Dr. Terry Bridle, the camp physician. These medications may be prescribed and administered by the nurse.

□ All prescription medications must be sent in the original container with the name of the medication, dosage information and the name of the camper clearly visible on the label. Medications must **not** be sent in an envelope or mechanical aid for self-administration such as a pill organizer. Please include a small extra supply of medications in case of an emergency.

□ On trips out of camp; personal medications are administered by staff who have been instructed by the nurse

□ For the camper with **anaphylaxis** who requires an auto-injector (epinephrine), please ensure equipment is labeled with the camper's name and the expiry date covers the total camp period. This medication should be carried in a waist pouch.

□ If a camper requires a prescription medication while at camp, the camp will invoice the parents for the cost at the end of the session. A receipt will be forwarded when payment is received.

□ For the camper with **asthma**, we recommend that puffers and auto-injectors be carried in a waist pouch.

□ If alternative or complementary remedies have been prescribed, please send them in the original container with the name visible and include the purpose, action and anticipated effects of the substance.

□ All medications brought by campers and staff, as well as those stocked by the camp are stored in a locked cupboard in the Health Centre. The medications required for emergency situations, such as Auto-injectors and Puffers, are carried by the individuals who require them.

□ Please keep the camp updated if there are any changes in the camper's health status and/or medications between the time the Health Form is submitted and the start of the camp session.

POLICY RE: TOBACCO, ALCOHOL AND RECREATIONAL DRUGS, CHEMICALS.

It is Camp Big Canoe policy to prohibit campers (including LIT and Outdoor skills) and staff from using: tobacco in any form; alcohol; or recreational (non-prescription) drugs and chemicals. Any violation of the policy results in immediate dismissal from camp.

POLICY re: HEALTH and SAFETY.

The health and safety of our campers is foremost in our planning. All our staff have been prepared in first aid. Waterfront staff have NLS certification from either The Lifesaving Society or the YMCA. It is camp policy to require the use of PFDs/life jackets in all boats in camp and on out trips. A “Buddy System” is in effect at all times on the waterfront.



2009 Health Form for Campers and Staff

- Purpose and Use** This information is being collected to allow the camp to be aware of the health of its campers and staff, to record any examinations or treatments given to them while at camp and to have it available if needed by medical personnel.
- Disclosure** The information provided will be kept confidential and not disclosed, but some or all of it:
- may be consulted by the camp nurse when providing health care to the individual;
 - may be disclosed to those staff members who, in the opinion of the camp director, need to know the information for the health and safety of the individual or the other individuals attending the camp;
 - may be disclosed to ambulance attendants, physicians, hospitals or clinics providing medical attention to the individual.

INDIVIDUAL AND FAMILY CONTACT INFORMATION

	CAMPER or STAFF	FATHER (or: _____)	MOTHER (or: _____)
Last name			
First name			
Commonly called *			
Middle name			
Address		IF DIFFERENT FROM THE CAMPER or STAFF	IF DIFFERENT FROM THE CAMPER or STAFF
Work phone	()	()	()
Cell phone	()	()	()
Home phone	()	() IF DIFFERENT	() IF DIFFERENT
Fax	()	()	()
E-mail			

* if the individual is commonly known by a name other than their first name (e.g. "Kit"), specify it here.

Emergency contact will be: ** Mother ____ Father ____

If emergency contact is not the Mother or Father, _____: whose relationship and contact info is

Name	Relationship to individual	
Address	Work phone	()
	Cell phone	()
E-mail	Home phone	()

**if the emergency contact will be at a different location (e.g. on holidays) while the individual will be at the camp, please attach a note with the necessary contact information.

MEDICAL INFORMATION

Sex: Male____ Female____ Age: (as of Jun 30 of the camp year) ____ Birth Date: ____/____/____
YYYY MM DD

Health Card Number: _____ Version Code: _____

Family Physician
 Name: _____ Phone: (____)_____ Date of last examination ____/____/____
YYYY MM DD

Other Physician (specialty _____)
 Name: _____ Phone: (____)_____ Date of last examination ____/____/____
YYYY MM DD

Physical Health History

General	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Prescribed earplugs	<input type="radio"/>	<input type="radio"/>	Eyeglasses/contacts	<input type="radio"/>	<input type="radio"/>
Dental prosthesis	<input type="radio"/>	<input type="radio"/>	Girl menstruated?	<input type="radio"/>	<input type="radio"/>
Carries auto-injector	<input type="radio"/>	<input type="radio"/>	Carries a "Puffer"	<input type="radio"/>	<input type="radio"/>
Wears a Medic Alert Bracelet – please explain diagnosis & medical history:			<input type="radio"/>	<input type="radio"/>	

Communicable Diseases	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Chicken Pox	<input type="radio"/>	<input type="radio"/>	Mononucleosis	<input type="radio"/>	<input type="radio"/>
Hepatitis	<input type="radio"/>	<input type="radio"/>	Mumps	<input type="radio"/>	<input type="radio"/>
Measles, Red	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>
Measles, German	<input type="radio"/>	<input type="radio"/>	Whooping Cough	<input type="radio"/>	<input type="radio"/>
Other (specify) _____					

Immunization	Year of last injection
TDP (Tetanus, Diphtheria, Polio)	_____
MMR (Measles, Mumps, Rubella)	_____
Hepatitis B	_____
Hib (Haemophilus influenza type B)	_____
TB/BCG (Tuberculosis)	_____
Varicella Vaccine (Chicken Pox)	_____
Pneumococcal Conjugate	_____
Meningococcal Conjugate C	_____

Other	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Asthma	<input type="radio"/>	<input type="radio"/>	Homesickness	<input type="radio"/>	<input type="radio"/>
Bedwetting	<input type="radio"/>	<input type="radio"/>	Hypertension	<input type="radio"/>	<input type="radio"/>
Bleeding Disorder	<input type="radio"/>	<input type="radio"/>	Seizure Disorder	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Sinus Infections	<input type="radio"/>	<input type="radio"/>
Earaches	<input type="radio"/>	<input type="radio"/>	Skin Condition	<input type="radio"/>	<input type="radio"/>
Eating Disorder	<input type="radio"/>	<input type="radio"/>	Sleepwalking	<input type="radio"/>	<input type="radio"/>
Frequent Colds	<input type="radio"/>	<input type="radio"/>	Sore Throats	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	Stomach Aches	<input type="radio"/>	<input type="radio"/>
Hearing Disorder	<input type="radio"/>	<input type="radio"/>	Urinary Tract Infections	<input type="radio"/>	<input type="radio"/>
Heart Condition	<input type="radio"/>	<input type="radio"/>	Vision Disorder	<input type="radio"/>	<input type="radio"/>
Other (specify) _____					

The above are being treated as follows:

Physical restrictions _____

Recent operations, illness or injury _____

Dietary needs _____

Activities to be specifically encouraged _____

Treatments or special medications to be given while at camp _____

Personal Prescription, Over-the-Counter, or Alternative/Complementary Medication
(brought in its original container with the individual's name, medication name, and dosage clearly visible)

Name of Medication	Dosage	How/When Administered	Reason for taking

Allergy History

(In all but the mildest reactions, we require detailed information about the individual's allergies to ensure adequate health care)

Allergies	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Foods	<input type="radio"/>	<input type="radio"/>	Medication	<input type="radio"/>	<input type="radio"/>
Insect Sting or Bite	<input type="radio"/>	<input type="radio"/>	Seasonal (hay fever)	<input type="radio"/>	<input type="radio"/>
Other (specify)	_____				

Where "yes", designate the allergy (s) and list the allergens (the substances which cause the reaction)

	<u>Allergy 1</u>	<u>Allergy 2</u>
Name: (e.g. bites)	_____	_____
Allergens:	_____	_____
	_____	_____
	_____	_____

Nature of Reaction	<u>Allergy 1</u>			<u>Allergy 2</u>		
	<u>Mild</u>	<u>Mod</u>	<u>Severe</u>	<u>Mild</u>	<u>Mod</u>	<u>Severe</u>
Hayfever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anaphylaxis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rash/Hives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Re the most serious reaction	<u>Allergy 1</u>	<u>Allergy 2</u>
Date of reaction	_____	_____
Symptoms	_____	_____
	_____	_____
	_____	_____

Current Medical Treatment	<u>Allergy 1</u>		<u>Allergy 2</u>	
	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>
None	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-prescription medication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prescribed medication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Desensitization program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Under the care of the family doctor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Under the care of an allergy specialist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide details and date of last treatment:	_____			

Past Medical Treatment	<u>Allergy 1</u>		<u>Allergy 2</u>	
	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>
Injection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doctor visit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emergency room	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital admission	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Management Ability of the Individual	<u>Allergy 1</u>		<u>Allergy 2</u>	
	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>
Recognizes the reaction on their own	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Treats the reaction on their own (e.g. knows how to use auto-injector)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Requires assistance by adult	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Requires assistance by medical staff	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please review with the individual, both their medication and management, before they come to the camp.

Precautions and Medication Taken	Allergy 1	Allergy 2
Regular medications (name/frequency)		
Medications as required (name/frequency)		
Emergency measures (type/instructions)		

