2014 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 (speciality _____)
Name: _____ Phone: (_____)_____ Date of last examination _____/_____/___
YYYY MM DD

Physical Health History

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

Communicable Diseases	Yes	No		Yes	No
Chicken Pox	O	O	Mononucleosis	O	O
Hepatitis	O	O	Mumps	O	O
Measles, Red	O	O	Tuberculosis	O	O
Measles, German	O	O	Whooping Cough	O	O
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	Yes	No		Yes	No
Asthma	O	O	Homesickness	O	O
Bedwetting	O	O	Hypertension	O	O
Bleeding Disorder	O	O	Seizure Disorder	O	O
Diabetes	O	O	Sinus Infections	O	O
Earaches	O	O	Skin Condition	O	O
Eating Disorder	O	O	Sleepwalking	O	O
Frequent Colds	O	O	Sore Throats	O	O
Headaches	O	O	Stomach Aches	O	O
Hearing Disorder	O	O	Urinary Tract Infections	O	O
Heart Condition	O	O	Vision Disorder	O	O
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** ***and*** ***sufficient quantity*****) PARENTS ... please request from the Pharmacist the product monograph AND send it to camp**

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	**Yes**	**No**		**Yes**	**No**
Foods	O	O	Medication	O	O
Insect Sting or Bite	O	O	Seasonal (hay fever)	O	O
Other (specify)					

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

	Allergy 1	**Allergy 2**
Name: (e.g. bites)		
Allergens:		

Nature of Reaction	**Allergy 1**			**Allergy 2**		
	Mild	**Mod**	**Severe**	**Mild**	**Mod**	**Severe**
Hayfever	O	O	O	O	O	O
Asthma	O	O	O	O	O	O
Anaphylaxis	O	O	O	O	O	O
Rash/Hives	O	O	O	O	O	O
Other _____	O	O	O	O	O	O

Re the most serious reaction	**Allergy 1**	**Allergy 2**
Date of reaction		
Symptoms		

Current Medical Treatment	**Allergy 1**		**Allergy 2**	
	Yes	**No**	**Yes**	**No**
None	O	O	O	O
Non-prescription medication	O	O	O	O
Prescribed medication	O	O	O	O
Desensitization program	O	O	O	O
Under the care of the family doctor	O	O	O	O
Under the care of an allergy specialist	O	O	O	O

Provide details and date of last treatment:

Past Medical Treatment	**Allergy 1**		**Allergy 2**	
	Yes	**No**	**Yes**	**No**
Injection	O	O	O	O
Doctor visit	O	O	O	O
Emergency room	O	O	O	O
Hospital admission	O	O	O	O

Management Ability of the Individual	**Allergy 1**		**Allergy 2**	
	Yes	**No**	**Yes**	**No**
Recognizes the reaction on their own	O	O	O	O
Treats the reaction on their own (e.g. knows how to use auto-injector)	O	O	O	O
Requires assistance by adult	O	O	O	O
Requires assistance by medical staff	O	O	O	O

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)		

Special Needs including Emotional Needs

	Yes	No		Yes	No
Concerns about coping (e.g. first overnight camp)	O	O	Emotional health concern	O	O
Diagnosed with Attention Deficit Disorder (ADD) or ADHD	O	O	Learning disability	O	O
Been the subject of bullying, or the bully				O	O
Psychiatric diagnosis such as depression, OCD, panic/anxiety disorder				O	O
Currently seeing a professional to address mental or emotional health concerns				O	O

If "yes" was the answer to any question in this section, please attach a statement from the physician or psychiatrist that:

- describes the concern and the individual's management plan (including medications);
- describes the behaviours that would indicate to our staff that the individual needs medical consultation;
- provides a recommendation for participation in the camp program;
- details what symptoms might be observed at the camp;
- suggests how the camp might manage the behaviour

What have we forgotten to ask? *Please provide information about the individual's emotional health that may have been neglected on this form. We are particularly interested in information that may impact upon the ability to fully participate in our program.*

CONSENT TO USE OF MEDICAL INFORMATION AND TREATMENT

I give permission for the information on this form to be used in accordance with the notes on the first page and I confirm that:

- To the best of my knowledge, except as noted on this form, the individual is in good health and is physically able to participate in all camp activities. I will notify the camp if the individual is exposed to an infectious disease during the three weeks prior to arriving at camp.
- The individual is covered by provincial or equivalent health insurance and it is up to the individual to bear the costs of any extra expenses required for their treatment that are not covered by the provincial or equivalent health insurance.
- In the case of medical or surgical emergency, the camp will try to contact the person designated as the emergency contact on this form but in the event that person cannot be contacted, I give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment, order injection, anaesthesia or surgery for the individual.

Note: *This consent must be signed by a parent or guardian, unless the individual is 18 years or older*

Signature: _____ Name: _____ Date: _____
(Please print)

NURSE'S NOTES

DATE (YY/MM/DD)	TIME	C/O	TREATMENT