## Personal Health Form

The information on this form will be used at the discretion of the Camp Director to ensure that the appropriate care and attention is given to the health of the participant. All information on this form is considered **Personal and Confidential!**

**Name** _____
*Surname* *Given Name*

**Address** _____
*No.* *Street* *Apt. No.* *P.O. Box or R.R. No.*

_____
*City* *Province* *Postal Code*

**Birth Date** ___/___/___
*Day/Month/Year*

**Height** _____

**Weight** _____

**Parent or Guardian** (or Spouse *if applicable*)

_____
*Surname* *Given Name*

Home Phone ( ) _____
Business Phone ( ) _____
Cellular Phone ( ) _____

Address (only if different from above)

_____
*No.* *Street* *Apt. No.* *P.O. Box or R.R. No.*

_____
*City* *Province* *Postal Code*

**If the above are unavailable in an emergency please notify:**
(a minimum of one emergency contact must be noted below…)

_____
*Surname* *Given Name*

Home Phone ( ) _____
Business Phone ( ) _____
Cellular Phone ( ) _____

_____
*No.* *Street* *Apt. No.* *P.O. Box or R.R. No.*

_____
*City* *Province* *Postal Code*

_____
*Surname* *Given Name*

Home Phone ( ) _____
Business Phone ( ) _____
Cellular Phone ( ) _____

_____
*No.* *Street* *Apt. No.* *P.O. Box or R.R. No.*

_____
*City* *Province* *Postal Code*

**Prov. Health Ins. No.** _____ **Family Dr**. _____ **Phone** ( ) _____

**Other Hospital Ins. No.** _____ **Subscriber's Name** _____

The events/program may include swimming, hiking, team sports, individual sports, camping etc. Does the applicant suffer from any physical or emotional disorder that would prevent her/him from participating fully in this program? _____ If so, please state full particulars:

_____
_____
_____

Occasionally, our activities are photographed or video taped & as such, sometimes used for promotional purposes. Do you have a concern with your youth being included?

No _____ Yes _____ _____
Signature of applicant, parent or guardian

**Name of Participant / Applicant:** _____

In order that the staff may provide the best care for the applicant, the following information would be useful:
Is the applicant currently subject to any of the following?

| | | | |
|---|---|---|---|
| ☐ Chicken Pox | ☐ Respiratory Ailments | ☐ Motion Sickness | ☐ Bed Wetting |
| ☐ Measles, Red | ☐ Ear Trouble | ☐ Headaches | ☐ Sleep Walking |
| ☐ Measles, German | ☐ Convulsions | ☐ Frequent Colds | ☐ Heart Condition |
| ☐ Mumps | ☐ Diabetes | ☐ Hernia | ☐ Arthritis |
| ☐ Whooping Cough | ☐ Fainting Spells | ☐ | ☐ Allergies – Please List |
| ☐ Hepatitis | ☐ Severe Stomach Aches | ☐ | ☐ Other – Please Specify |

| | | | |
|---|---|---|---|
| Is Camper allergic to: | ☐ Penicillin | ☐ Other drugs _____ | ☐ Bee Stings |
| | ☐ Foods _____ | ☐ Peanuts | ☐ Other _____ |

**If your child has a serious or potentially life threatening allergy (eg. Bee stings, peanuts etc.) he/she must come to camp with his/her own personal EPIPEN (or equivalent injectable adrenalin) and camp staff be so notified.**

☐ Is camper fully immunized? Check if yes. Date of most recent tetanus booster: ____/____/____

Has the female applicant menstruated? _____ Has she been told about menstruation? _____

Please specify any chronic conditions or recent illnesses that the staff should be aware of and give details of the type of reaction and of the usual first aid treatment given:

_____

_____

_____

Please list any medication which the applicant is bringing with them. Such prescribed medication must be in the original container and properly labeled and given to the nurse or Camp Director upon arrival.

_____

_____

_____

**IMPORTANT: EVERY CARE AND ATTENTION WILL BE GIVEN TO THE HEALTH AND COMPORT OF THE CAMPER!**

To the best of my knowledge, my child is in good health and has not been exposed to any infectious disease in the past four weeks and is physically able to participate in all Camp activities, except as previously noted.

I hereby authorize the First-Aider or Leader-in-Charge of the event to secure such medical advice and services as may be deemed necessary for the health and safety of myself, my child or ward. I agree to accept financial responsibility in excess of the benefits allowed by Provincial Health Insurance Plan.

_____ _____

*Signature of Applicant or parent/guardian if applicant is under Prov. Legal Age* *Date*

**Provincial Health Cards** --- *An Important Note*

Due to legislated regulations it is mandatory to be able to present the original Provincial Health Card to the treating Professional. They cannot refuse critical care but will detain the individual until payment is made or the original and appropriate health card is produced.

***Photocopies will NOT be valid!***