

**This information is essential. Both sides of this form must be completed and signed by a parent or guardian and returned with registration form.**

Date of Camp: \_\_\_\_\_ Camper's Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male: \_\_\_\_ Female: \_\_\_\_  
                  dd mm yy

Health Card Number: \_\_\_\_\_ Letter Code: \_\_\_\_\_

Other Medical Plans

Family Physician's Name: \_\_\_\_\_ Telephone: # (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Date of Last Physical Exam: \_\_\_\_\_

Name of Parent(s)/Guardian(s): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone #: Home (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Alternate Contact: Name: \_\_\_\_\_ Telephone #: (\_\_\_\_) \_\_\_\_\_

Recent illness or exposure to infectious illness in the month prior to camp date (e.g. measles, mumps, diarrhea, etc.):

Athlete's Foot? \_\_\_\_\_ Treatment: \_\_\_\_\_

Has menstruation been explained to female camper? \_\_\_\_\_ Has menstruation begun? \_\_\_\_\_

Please list any menstruation difficulties: \_\_\_\_\_

Circle illnesses the camper has had:

- Measles (red)                      Mumps
- Measles (German)                Chicken Pox
- Whooping Cough (recent)        Hepatitis
- Heart Condition                    Rheumatic Fever
- Seizures                              Sleep Walking

Is camper subject to:

- Hay Fever                      Fainting Spells
- Asthma                          Bee Sting Reactions
- Recurrent throat
- Ear Infections
- Headaches

**ALLERGIES AND ADVERSE REACTIONS**

SUBSTANCE: \_\_\_\_\_ REACTION: \_\_\_\_\_

TREATMENT:

\_\_\_\_\_ Preferred pain or fever medication (e.g. Tylenol, aspirin): \_\_\_\_\_

HAS CAMPER HAD PREVIOUS REACTION TO: PENICILLIN? \_\_\_\_\_ BEE STINGS? \_\_\_\_\_ OTHER? PLEASE SPECIFY \_\_\_\_\_

IS CAMPER DIABETIC? \_\_\_\_\_ EPILEPTIC? \_\_\_\_\_ ASTHMATIC? \_\_\_\_\_

**REVERSE SIDE MUST BE COMPLETED**

**DIETARY INFORMATION**

DIET: REGULAR \_\_\_\_\_ SPECIAL \_\_\_\_\_ PLEASE SPECIFY TYPE AND REASON FOR SPECIAL DIET

\_\_\_\_\_  
LIST ANY FOOD ALLERGIES.

\_\_\_\_\_  
Other comments or concerns:

\_\_\_\_\_

**IMMUNIZATION INFORMATION**

Diphtheria, Whooping Cough, Tetanus, Polio

Date \_\_\_\_\_

Red Measles, Mumps, German Measles

Date \_\_\_\_\_

Tetanus Booster

Date \_\_\_\_\_

Any physical, emotional, or mental conditions not already listed? Present illnesses or infections?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CURRENT TREATMENT (medications including vitamins or restrictions during stay at camp – include name, dose and frequency) :

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

the camp cannot administer medications without precise information from the prescribing doctor. This includes prescription drugs, insulin and antihistamines.

Please note: all medications must be given to the camp nurse at registration time. All medications must be in their original containers and labelled with instructions and the user's name. This requirement applies to all non-prescription drugs as well.

To the best of my knowledge, this person is in good health, free from any communicable diseases or any infectious agents thereof, and is physically able to participate in all camp activities previously indicated. In case of medical emergency, I understand every effort will be made to contact parents or guardians. If unavailable, I give permission to contact the physician indicated on the reverse for medical information and consent for medical care or my child as deemed necessary by the attending physician. I understand that I will be informed as soon as possible if this has been done.

Date: \_\_\_\_\_ Signature of parent or guardian: \_\_\_\_\_

**SUBMIT HEALTH CARDS ON ARRIVAL AT CAMP**

Note: A Physician need NOT sign this form.