



92 Pine Post Road, P.O. Box 1042  
 Roches Point, Ontario  
 L0E 1P0

## CAMPER HEALTH FORM

**TO BE COMPLETED BY PARENTS/GUARDIANS AND RETURNED PRIOR TO YOUR CHILD'S FIRST DAY OF CAMP. *Thank you for your cooperation.***

<b>Camper's First Name:</b>	<b>Last Name:</b>
<b>Gender:</b> Male/ Female	<b>Date of Birth:</b>
<b>Week(s) Enrolled</b> (please refer to Parent Handbook page 1):	
1       2       3       4       5       6       7       8	
<b>Camper's Weight:</b>	<b>Health Card No:</b>
<b>Height:</b>	
<b>Mother's Information:</b>	<b>Father's Information:</b>
Name: _____	Name: _____
Home Phone #: _____	Home Phone #: _____
Bus. Phone #: _____	Bus. Phone #: _____
Cell #: _____	Cell #: _____
<b>Emergency Contact Information:</b>	
1. Name: _____	2. Name: _____
Relationship to Camper: _____	Relationship to Camper: _____
Phone Number(s): _____	Phone Number(s): _____
<b>Family Doctor:</b>	<b>Telephone:</b>
<b>Does your child have any physical limitations? YES / NO.</b> If yes, please describe them and indicate if they will prevent the child from participating fully in camp activities.	
<b>Does your child have any behavioral/emotional/family problems that might affect his/her ability to relate with camp staff, other campers and/or the general camp program? YES / NO.</b> If yes, please explain.	

**Medical History:**

**1. Has your child had or does your child have any of the following: If yes, please check.**

- Chicken Pox
- Heart Condition
- Kidney Trouble
- Tuberculosis
- Tonsillectomy
- Hepatitis
- Sinus Trouble
- Hernia Repair
- Frequent Colds
- Whooping Cough
- Red Measles
- Diabetes
- Mumps
- Adenoidectomy
- Scarlet Fever
- Hay Fever
- German Measles
- Fainting Spells
- Asthma
- Stomach Aches

*If you checked any of the above, please provide dates and any additional information.*

**2. Does your child have seizures? YES/ NO**

*If yes, please describe the type of seizure activity:*

**3. Please complete the following immunization chart.**

<b>BOOSTER SHOT</b>	<b>CHECK IF "YES"</b>	<b>DATE</b>
Polio		
Pertussis		
Diphtheria		
Tetanus		
MMR		

**4. If your child has known allergies please complete the following chart.**

	<b>SUBSTANCE</b>	<b>REACTION</b>	<b>TREATMENT</b>
<b>FOOD</b>			
<b>MEDICATION</b>			
<b>BITES / STINGS</b>			
<b>OTHER</b> (please specify)			

**5. Can we give your child Camp-provided snacks/drinks? YES/ NO**

**6. Is your child on any regularly scheduled medication? YES / NO** *If yes, please list*

<b>DRUG</b>	<b>DOSE</b>	<b>TIME</b>	<b>ROUTINE</b>

If you require the Camp to administer your child's medication during the camp day, the original container with prescribed instructions must accompany the medication.

_____	_____	_____
_____	_____	_____