



Winter: Tel: 416.410.9460

Summer: Tel: 905.476.2121

email: info@campkatonim.com

92 Pine Post Road, Roches Point, ON L0E 1P0

www.campkatonim.com

CAMPER HEALTH FORM

**TO BE COMPLETED BY PARENTS/GUARDIANS
PRIOR TO YOUR CHILD'S FIRST DAY OF CAMP and MAILED TO**

Before June 25
50 Fraserwood Rd.
Thornhill, ON
L4J 9C8

After June 25
92 Pine Post Road
P.O. Box 1042
Roches Point, ON
L03 1P0

Camper's First Name:	Last Name:
Gender: Male/ Female	Date of Birth:
Week(s) Enrolled (please refer to Parent Handbook page 1):	
<div style="display: flex; justify-content: space-around; width: 100%;"> 1 2 3 4 5 6 7 8 </div>	
Camper's Weight: Height:	Health Card No:
Mother's Information: Name: _____ Home Phone #: _____ Bus. Phone #: _____ Cell #: _____	Father's Information: Name: _____ Home Phone #: _____ Bus. Phone #: _____ Cell #: _____
Emergency Contact Information: 1. Name: _____ Relationship to Camper: _____ Phone Number(s): _____	2. Name: _____ Relationship to Camper: _____ Phone Number(s): _____
Family Doctor:	Telephone:
Does your child have any physical limitations? YES / NO. If yes, please describe them and indicate if they will prevent the child from participating fully in camp activities.	
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. 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.

BOOSTER SHOT	CHECK IF "YES"	DATE
Polio		
Pertussis		
Diphtheria		
Tetanus		
MMR		

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

	SUBSTANCE	REACTION	TREATMENT
FOOD			
MEDICATION			
BITES / STINGS			
OTHER (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*

DRUG	DOSE	TIME	ROUTINE

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.

To the best of my/our knowledge, this child is in good health and is physically able to participate in all camp activities except as indicated. If there are any medical problems that require on-going supervision or care, a referral letter from this child's physician will be forthcoming. In the event of an emergency and/or special medical treatment, parents will be notified immediately. If a parent cannot be reached, permission is hereby given to Camp Katonim to take whatever steps it deems necessary to ensure the safety and health of this camper. The undersigned also gives permission to the Camp to contact the camper's family physician. I understand that it is the parent's responsibility to advise the Camp IN WRITING if there are any medical changes in this camper before or during the camp season.

Parent or Guardian **Signature**

Print Name of Parent/Guardian

Date

Parent or Guardian **Signature**

Print Name of Parent/Guardian

Date

If only one parent/guardian signs as to the truth, completeness and contents of this form, the Camp may rely on the authority of such one parent/guardian and assume that he/she fully represents any non-signing parent/guardian.