



CAMP HURONTARIO HEALTH FORM – 2010

(To be returned with confirmation and camper forms by April 30th)
Please fill in with full details, adding a letter if needed.

Camper Name: _____ Age: _____
(Last) (Middle) (First) D/M/Y

Session: 3 1/2 weeks: June 30th to July 24th _____ July 28th to August 21st _____

Two weeks: June 30th to July 12th _____ July 12th to July 24th _____

Two weeks: July 28th to August 9th _____ August 9th to August 21st _____

Introcamp: July 13th to July 17th _____ July 9th to July 17th _____

Introcamp: August 10th to Aug. 14th _____ August 6th to Aug. 14th _____

Name of Father: _____
(Last) (First)

Address of Father: _____
(Street)

(City) (Province) (Postal Code)

Home Phone #: () _____ Business Phone #: () _____
(Please give complete dialling details for all phone numbers)

Cell number: () _____ Fax number: () _____

Email: _____

Name of Mother: Mrs./Ms./Dr. _____
(Last name) (First name)

Address of Mother: (if differs from above) _____
(Street)

(City) (Province)

(Postal code)

Home Phone #: () _____ Business Phone #: () _____
(Please give complete dialling details for all phone numbers)

Cell number: () _____ Fax number: () _____

Email address of mother: _____

HEALTH FORM (CONT'D)

Family Physician _____ Phone No. () _____
 (complete dialling details)

Address of Physician _____
 (Street)

_____ Postal Code _____
 (City) (Province)

Camper's Health Card number and Version Code: _____

Card Subscriber's Name: _____

Other Insurance (if applicable): _____

ALLERGIES: Please read carefully. Please be very specific when filling out medical details

Has your son had any allergies or adverse reactions to any medicines or medical products? Please write a detailed account. _____

Are there any other allergies of which the camp should be aware? Please list and specify in full detail – reaction, medication, actions which should be given and taken (or not) in relation to your son's allergy. A detailed letter may be required from you.

Please let us know if your son handles his own medication or if it should be given by the Counsellor or the Doctor. Details of dosage, frequency must be included. On trip, counsellors will give medication as directed by the medical staff at camp.

Medicine to be given by : _____

Details of medication _____

Please fill in with as much detail as possible the following (if applicable to your son).

1. List current medical conditions.

2. List significant past illnesses and surgeries. _____

**PLEASE STATE TREATMENT TO BE GIVEN (OR NOT) SHOULD CONDITION OCCUR:
 (please detail best procedure in a letter for a camper who bed wets – i.e. lifting at night, no water at night etc.)**

MEDICAL HISTORY

IMMUNISATION HISTORY

IS THE CAMPER FULLY IMMUNISED AGAINST:

Measles / Mumps / Rubella (MMR) ___ Has the camper had chicken pox or chicken pox vaccine? _____

Date of Last Tetanus Shot (important) _____

H1N1 Vaccination:

My son has _____/has not _____ received an H1N1 shot.

INFORMATION TO ASSIST THE COUNSELLOR

Does your son wear glasses / contact lenses? _____ All the time? _____

Does your son wear an orthodontic appliance? _____ For what period of the day? _____

Is there any emotional or physical situation about which the camp should be aware and which would be helpful for his counsellor to know? (All matters are kept private).

Hurontario's Policy on Calling Parents concerning health situations:

Hurontario's medical staff will call a parent or guardian if a camper has to be removed from his cabin group due to illness or is taken off the camp island for medical concerns. If antibiotics are administered at the camp by our Doctor, or if stitches are required, a letter from our Doctor will be sent home at the end of each session.

PLEASE READ and SIGN

To the best of my knowledge, my child is in good health and has not been exposed to chicken pox or any infectious disease prior to his departure for camp. If he does become exposed, I understand the camp must be notified. If need arises, I give permission for the family physician to be contacted. In case of surgical emergency and I am not available for consultation, I hereby give permission to the physician selected by the camp to hospitalise, secure proper treatment for and to order injections, anaesthesia or surgery for my child. Should it be necessary for a camper to return home, transportation will be arranged by a parent or guardian.

Date: _____ Signature: _____ (_____)

Please state association to camper after signature