CAMP SCUGOG HEALTH FORM

Return to: Camp Scugog, 50 Edward St., Brantford, ON N3S 1V3 • 905-837-0648

CAMPER NAME: Date of Birth (d/m/y): Age: Session #

If there is not enough space on this form, please attach a separate page with additional information.
I have attached a separate page. ☐ **yes** ☐ **no**

Name of parent(s) / guardian(s) with legal custody: ____

Hm.Tel. (____)________________ Cell Tel. (____)________________ Bus. Tel.(____)________________

Health Card #: ____________________________________(_______) Last Tetanus shot: _________________
expiry

Family Doctor: ____ Tel. (____)_____________________

Please check (√) as many as apply.

☐ seizures	☐ bladder infections	☐ depression	☐ ear aches	☐ menstruation
☐ HIV (+)	☐ fainting spells	☐ hepatitis	☐ stomach aches	☐ carries a puffer
☐ anxiety	☐ smoker	☐ sore throats	☐ hemophilia	☐ carries an Epi Pen
☐ ADD	☐ ADHD	☐ headaches	☐ learning disability	☐ asthma
☐ OCD	☐ ODD	☐ diabetes	☐ treated for head lice	☐ eczema

Dietary restrictions:

☐ vegetarian ☐ vegan ☐ lactose intolerant ☐ gluten free ☐ no beef ☐ no pork ☐ other _________________

Allergies: Drug / Food / Life Threatening / Other: (we are NOT peanut free):

____

____

Camper is in compliance with all recommended vacinations: ☐ yes ☐ no (*Please specify)

Diagnosed Disorder(s)/ Disability(s)/ Mental Health concerns: ______________________________________

____

Past Medical History: ____

Prescriptions taken this past year that you will NOT be continuing while at camp: __________________

____

Recent operations, illness or injury: ____

Prescription, Over-the-Counter, or Alternative Medication to be taken at camp.
(please bring in **original container** with the camper name, medication name, Doctor name and phone # and dosage clearly visible)

Name of Medication	Dosage	How/When Administered	Reason for Taking

I confirm that to the best of my knowledge, except as noted on this form, this person is in good health and physically able to participate in all camp activities. I will notify the camp in writing if the individual is exposed to an infectious disease during the three weeks prior to arriving at camp. In the case of medical or surgical emergency, the camp will contact the parent/guardian or emergency contact on this form. In the event that person cannot be contacted, I give permission to the physician selected by the Camp Director or other responsible individual to call for ambulance, secure proper treatment, hospitalize, order injection, anaesthesia or surgery for the camper named in this form.

_______________________________ _______________________________ _________________
Parent / Legal Guardian Signature Print Name Date