

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.

- | | | | | |
|-----------------------------------|---|---------------------------------------|--|---|
| <input type="checkbox"/> seizures | <input type="checkbox"/> bladder infections | <input type="checkbox"/> depression | <input type="checkbox"/> ear aches | <input type="checkbox"/> menstruation |
| <input type="checkbox"/> HIV (+) | <input type="checkbox"/> fainting spells | <input type="checkbox"/> hepatitis | <input type="checkbox"/> stomach aches | <input type="checkbox"/> carries a puffer |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> smoker | <input type="checkbox"/> sore throats | <input type="checkbox"/> hemophilia | <input type="checkbox"/> carries an Epi Pen |
| <input type="checkbox"/> ADD | <input type="checkbox"/> ADHD | <input type="checkbox"/> headaches | <input type="checkbox"/> learning disability | <input type="checkbox"/> asthma |
| <input type="checkbox"/> OCD | <input type="checkbox"/> ODD | <input type="checkbox"/> diabetes | <input type="checkbox"/> treated for head lice | <input type="checkbox"/> 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 and available COVID-19 vaccinations: yes no

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 _____