

MOORELANDS CAMP HEALTH HISTORY FORM 2009

Please Use Pen and Print. Incomplete forms will be returned.

CAMPER INFORMATION

Camper's Last Name: _____ **Health Card Number:** _____
Camper's First Name: _____ **Version Code Initials:** _____
Street: _____ **Expiry Date:** _____
YEAR / MONTH / DAY
Apt/Unit: _____ **Is this card a Red & White card?** No Yes
City: _____ **Family Doctor's name:** _____
Postal Code: _____ **Doctor's Phone:** _____
Gender: Male Female
Birthdate: _____ **Age:** _____ **Height:** _____ **Weight:** _____
MONTH / DAY / YEAR

CONTACT INFORMATION While this camper is at camp the contacts listed below **must be available** for contact. If contact numbers change notify the camp.

Parent/Step-Parent / Guardian: Mr / Mrs / Mr & Mrs / Ms / Miss **Emergency Contact Name:** Mr / Mrs / Mr & Mrs / Ms / Miss
Address _____ **Address** _____
Home Phone: _____ **Home Phone:** _____
Business Phone: _____ **Business Phone:** _____
Cell Phone: _____ **Cell Phone:** _____
Email: _____ **Email:** _____

IMMUNIZATION: Indicate date last given

Diphtheria	MMR	Hepatitis B	Pertussis (Whooping Cough)
Polio	Tetanus	Varifax <small>(Chickenpox)</small>	

ALLERGIES

Foods: _____
Medication: _____
Other (i.e. bee stings): _____
 Does this camper carry and EpiPen/Twinjet? NO Yes for the following allergy:
 Campers requiring an EPIPEN/Twinjet must provide their own fanny pack and carry their EPIPEN/Twinjet at all times.

DIETARY CONCERNS/RESTRICTIONS: List dietary concerns/restrictions the Camp should be aware of i.e. vegetarian, lactose intolerance, etc.

Indicate if camper has or has had any of the following:

	Has	Had		Has	Had		Has	Had		Has	Had
Athlete's Foot	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Walking	<input type="checkbox"/>	<input type="checkbox"/>	Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>	Cystitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Red Measles	<input type="checkbox"/>	<input type="checkbox"/>	Toothaches	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	German Measles	<input type="checkbox"/>	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Ear Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Motion Sickness	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Aches	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Other(specify): _____						Operations:					

Check if the camper uses: Eye Glasses Contact Lenses Dental Appliance Prescribed Earplugs

Camper Last Name: _____ First Name: _____

<p>Does camper have current medical conditions, long or short term? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, please explain:</p>	<p>Does camper have ADD / ADHD? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES is camper receiving medication? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, complete section B. <i>Campers taking medication for ADD/ADHD during the school year are expected to continue medication while at camp.</i></p>
<p>Does camper have emotional or behavioural difficulties? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES please explain:</p>	<p>Does this camper have asthma? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES does camper use inhalers? <input type="checkbox"/> NO <input type="checkbox"/> YES If YES complete Section B. <i>While at camp inhalers MUST be carried by campers at ALL times in their own fanny pack.</i></p>
<p>Does camper have any physical limitation and/or activity restrictions (cannot take part in an activity)? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, please explain:</p>	<p>Camper is currently under care of physician for:</p>

LIST ALL MEDICATION(DRUG), TREATMENT/CONDITION FOR WHICH PRESCRIBED, DOSAGE AND DIRECTIONS

Note: Campers receiving medication during the school year for behavioural or focusing reasons are expected to continue medication while at camp.

If your camper is taking medication for asthma please include a copy of his/her Asthma Action Plan

ALL MEDICATION MUST BE IN ORIGINAL CONTAINERS WITH CURRENT LABELS, DOSAGE AND DIRECTIONS AND HANDED IN AT THE BUS REGISTRATION.

To the best of my knowledge, the above named camper is in good health. Should the camper be in contact with an infectious disease or should there be changes to the above information before departure for camp I understand that I must notify the camp city registrar at 416-466-9987 ext. 0. I give permission for the Camp Nurse or Camp Director or designate to contact the emergency contact and/or the physician as required. If I am not available for consultation in case of emergency, I hereby authorize the Camp Director, Camp Nurse or designate to secure such medical advice and services (including hospitalization, anaesthesia, surgery and dental care) as may be deemed necessary by a physician.

Date:..... Signature:
 Parent or guardian if camper under 18 years of age

THIS FORM MUST BE RECEIVED ONE MONTH PRIOR TO YOUR CHILD LEAVING FOR CAMP.

**Send completed form to :
 MOORELANDS CAMP 250 MERTON STREET Suite 501 TORONTO ON M4S 1B1**

For Camp Use Only:
 Camp Health Check date: _____ performed by _____
 Notes: