

Staff Medical Form - Camp Mini-Yo-We

Staff Surname

First Name

Camp Session (e.g. Boys Week 2)

Dates at Camp

Year at Camp

Staff INFORMATION: Please PRINT clearly in BLOCK letters

Staff's Full Name: Surname _____ Given Name(s) _____
 (as it appears on Health Card)

Street Address: _____ Sex: M F

City/Prov/Postal Code: _____ Birth Date: ____/____/____

Telephone: (____) _____ Age at Camp: _____

NUMBERS: **Please attach a photocopy of Provincial Health Card**

Health Card Number: _____ Issuing Province: _____

A VISA or MASTERCARD number **must be supplied** to pay for medical treatment(s) not covered by provincial health plans, e.g. prescription drugs. Also, **NON-CANADIAN RESIDENTS** will have all medical treatment billed to this card, as other health insurance plans are not accepted by health care providers and hospitals. You will be notified and provided with receipts to submit to your insurance plan if expenses are incurred.

Credit Card #: _____ Exp: ____/____ VISA
 MASTERCARD

Name on Credit Card: _____

CONTACTS:

	Name	Home Phone	Work Phone	Cell Phone	Relationship
Primary:	_____	(____) _____	(____) _____	(____) _____	_____
Secondary:	_____	(____) _____	(____) _____	(____) _____	_____
Physician:	_____	(____) _____	(____) _____	(____) _____	_____

If we are not able to reach an emergency contact, we may contact the family physician for more medical information.

HEALTH HISTORY: (Call camp office at least 2 weeks prior to camp arrival to arrange discussion of major concerns with camp nurse)

Any medical, emotional or behavioural condition(s) must be fully disclosed on this health form

Medical Conditions None

<input type="checkbox"/> Hepatitis B, C	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Seizures
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Crohns	<input type="checkbox"/> Depression	<input type="checkbox"/> Visual Problems	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Cancer	<input type="checkbox"/> Colitis	<input type="checkbox"/> Fetal Alcohol Syndrome	<input type="checkbox"/> Mouth Injuries	<input type="checkbox"/> Asthma/Inhalers
<input type="checkbox"/> Downs Syndrome	<input type="checkbox"/> Developmental Delays	<input type="checkbox"/> Mental Health Issues	<input type="checkbox"/> Behavioural Issues	<input type="checkbox"/> Other _____

Describe: _____

Current Problems None

<input type="checkbox"/> Constipation	<input type="checkbox"/> Homesickness	<input type="checkbox"/> Nightmares/Terrors	<input type="checkbox"/> Sinus Infections
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Headaches	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Ear Infections
<input type="checkbox"/> Stomach Aches	<input type="checkbox"/> Sleepwalking	<input type="checkbox"/> Sore Throats	<input type="checkbox"/> Other _____

Describe: _____

Surgical History (insert date beside surgery) None

<input type="checkbox"/> Heart	<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Ear Tubes	<input type="checkbox"/> Other _____
<input type="checkbox"/> Orthopedic	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Hernia Repair	

Describe: _____

Allergies & Dietary Considerations None

Drug Allergies	Environmental Allergies	Food Allergies	Special Diet
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Bee Stings	<input type="checkbox"/> Lactose Intolerant	<input type="checkbox"/> Vegetarian
<input type="checkbox"/> Sulfa	<input type="checkbox"/> Pollen	<input type="checkbox"/> Shellfish	<input type="checkbox"/> Lactose-free
<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> Hayfever	<input type="checkbox"/> Peanuts	
<input type="checkbox"/> Anaesthetic	<input type="checkbox"/> Animal Dander	<input type="checkbox"/> Nuts	List foods to avoid for medical reasons:
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> Dust/Mold	<input type="checkbox"/> Food Dye	_____
<input type="checkbox"/> Codeine	<input type="checkbox"/> Tape	<input type="checkbox"/> Gluten	_____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	_____

Describe reaction(s): _____

	Yes	No
Anaphylactic reaction to allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Epi Pen?	<input type="checkbox"/>	<input type="checkbox"/>
Knowledge of Epi Pen use?	<input type="checkbox"/>	<input type="checkbox"/>

****You must bring a fanny pack & at least 2 epi pens****

MEDICATIONS BEING BROUGHT TO CAMP: None (attach additional sheet if necessary)

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency
1. _____	_____	_____	4. _____	_____	_____
2. _____	_____	_____	5. _____	_____	_____
3. _____	_____	_____	6. _____	_____	_____

All non-prescription medication, e.g. vitamins and Tylenol, must come to camp in their **original packages** clearly labeled with your name and instructions. All prescribed medications must come in their **original container with a clear pharmacy label** including current dose and frequency for medications to be given at camp. Prescriptions must only be in your name; check expiry dates of medications.

To the best of my knowledge I am in good health. In the case of medical emergency, I understand that effort will be made to contact the aforementioned individuals. In the event they cannot be reached, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment, order injection, anesthesia or surgery for me. By signing, I also give permission, if necessary, for the above credit card number to be used to assist in treatment.

Signature: _____ **Date:** _____

PLEASE BRING THIS FORM TO CAMP AT TIME OF ARRIVAL