CAMP TIMBERLANE HEALTH RECORD

(To be completed by the parent or guardian)

THIS FORM MUST BE RETURNED TO THE CAMP OFFICE BY JUNE 1st, 2009

NAME: ____

LAST **FIRST**

DATE OF BIRTH: __________ **HEIGHT:** _____ **WEIGHT:** ______ **HEALTH CARD #/INSURANCE:** ______________________

M/D/Y **Version code**

PARENTS NAMES: ____________/____________ **HOME PHONE:** ____________________

FATHER **MOTHER**

CELL PHONE: ____________/____________ **SUMMER PHONE:** ____________________

FATHER **MOTHER**

BUSINESS PHONE : ____________/____________ **PAGER NUMBER:** ____________________

FATHER **MOTHER**

In case of illness or sickness is there a primary parent to contact? ________________________

(When either parents are unable to be reached) please notify:

1) NAME: ______________________ **HOME PHONE:** ______________ **CELL:** ______________

WORK: ______________ **SUMMER PHONE:** ______________ **PAGER:** ______________

RELATIONSHIP WITH CAMPER: ______________

2) NAME: ______________________ **HOME PHONE:** ______________ **CELL:** ______________

WORK: ______________ **SUMMER PHONE:** ______________ **PAGER:** ______________

RELATIONSHIP WITH CAMPER: ______________

May this person authorize medical treatment in the event a parent cannot be contacted in a medical emergency?

Yes ________ **No** ________

NAME OF PHYSICIAN: ______________________________ **TEL :** ______________________

ADDRESS: ____

If the camper has had any of the following please check:

___Chicken pox	___Measles, red	___Measles, german	___ Heart Condition
___Seizures of any kind	___Abdominal pain	___Whooping cough	___ Sleep Walking
___Asthma	___Mononucleosis	___Hay Fever	___ Ear trouble
___Emotional Illness	___Hepatitis	___Dental Problems	___ Rheumatic Fever
___ Frequent Colds			

Please detail any recent problems or elaborate on any of the above:

____

____

Has the girl menstruated?____ **Any problems?**________________________

Please verify the full immunized status of the child against all of the following if applicable:

____**Pertussis** ____ **Tetanus** ____ **Diptheria** _____**MMR** _____**Meningitis (Menjugate/Prevnar)** _____ **Chicken Pox (Varicella)**

____ **Hepatitis A** ____ **Hepatitis B** _____ **Polio**

Date of most recent Tetanus Booster (yy/mm/dd):______________

Does your child have any MEDICATION ALLERGIES:

____

Does your child have any FOOD ALLERGIES:

____

Does he/she carry an Epipen? __________________ Has your child had an anaphylactic reaction and if so please advise when and severity:

Does your child have ADD/ADHD? ____

If so, are they on medication? ____

Any surgeries or injuries in the last year? ____

Does the child have any physical limitations/activity restrictions/and/or chronic illness? ___________________________________

Has your child ever had an eating disorder or displayed similar symptoms? ____

Please state any physical or emotional abnormalities and any other information that may be useful to the camp physician:

If there are any special treatments, injections, diets or medicine to be administered at camp, please detail these. Any required materials should be brought with the camper in sufficient quantity to last for their stay:

I have fully disclosed all medical, psychological and/or emotional problems or concerns. I hereby give permission to the physician/and or camp staff selected by the Camp Director to hospitalize, secure proper treatment for, and/or to order and secure necessary related transportation, injections, anesthetics or surgery for my child as named above. I hereby waive, release and absolve and agree to indemnify and save harmless the camp and their respective officers, employees and agents from all liability arising from my child's participation in their program, except such as results solely from its or their willful neglect or willful default. I confirm that my child is capable in participating safely in a full program including all trips/canoe trips and activities unless I advise you otherwise in writing and I acknowledge that such participation involves risks and hazards incidental thereto all of which assumed by me. I agree to be responsible for any extra medical expenses incurred by my child or by the camp on behalf of my child. I acknowledge that any medical treatment will be performed in the Province of Ontario and that the Courts of Ontario shall have jurisdiction over any claim, legal disputes or commencement of a legal proceeding against Camp and/or the camp medical staff, (which includes the camp's physician or nurse) alleged breach of contract, or alleged negligence or other claim that leads to the commencement of a legal proceeding of a legal proceeding against the Camp and/or the camp medical staff. I hereby agree that if I commence any such legal proceedings they will be held only in the Province of Ontario and I hereby irrevocably submit to the exclusive jurisdiction of the Courts of the Province of Ontario. I further agree that the resolution of any and all disputes arising between the Camp and/or its medical staff shall be governed and construed in accordance with the laws of the Province of Ontario. **PLEASE NOTE: Medications – prescription or over the counter drugs, will be administered only if they are properly labeled with written instructions detailing how to dispense the medication.**

Parent/Guardian's Name:____

Signature:____

Date:____________

Doctors Notes

DATE	TREATMENT	DR/NURSE