

LAKE SCUGOG CAMP HEALTH FORM

Return to: Registrar, Lake Scugog Camp, 1757 Broadoak Cres. Pickering, ON L1V4S6 • 905-837-0648

CAMPER NAME: _____	Date of Birth: _____	Age: _____	Session # _____
Name of parent(s) / guardian(s) with legal custody: _____			
Hm. Tel. (____) _____ Cell Tel. (____) _____ Bus. Tel. (____) _____			
Health Card #: _____ (____) Last Tetanus shot: _____ <small>expiry</small>			
Family Doctor: _____ Telephone: (____) _____			
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"/> HIV (+)	<input type="checkbox"/> fainting spells	<input type="checkbox"/> hepatitis	<input type="checkbox"/> stomach aches
<input type="checkbox"/> anxiety	<input type="checkbox"/> smoker	<input type="checkbox"/> sore throats	<input type="checkbox"/> hemophilia
<input type="checkbox"/> ADD	<input type="checkbox"/> ADHD	<input type="checkbox"/> headaches	<input type="checkbox"/> learning disability
<input type="checkbox"/> OCD	<input type="checkbox"/> ODD	<input type="checkbox"/> diabetes	<input type="checkbox"/> treated for head lice
			<input type="checkbox"/> menstruation
			<input type="checkbox"/> carries a puffer
			<input type="checkbox"/> carries an Epi Pen
			<input type="checkbox"/> asthma
			<input type="checkbox"/> other _____
Dietary restrictions:			
<input type="checkbox"/> vegetarian	<input type="checkbox"/> lactose intolerant	<input type="checkbox"/> religious restrictions	_____
Allergies: Drug / Food / Other: (describe) _____			
Any life threatening allergies? (we are NOT peanut free): _____			
Diagnosed Disorder(s)/ Disability(s): _____			
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 <u>original container</u> with the camper name, medication name, Doctor name and phone # and dosage clearly visible)			
Name of Medication	Dosage	How/When Administered	Reason for Taking
<p>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.</p> <p>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 to call for ambulance, secure proper treatment, hospitalize, order injection, anaesthesia or surgery for the individual.</p>			
Parent / Legal Guardian Signature _____		Print Name _____	Date _____