

ATLANTIC BURN CAMP

Health Form for Children

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Part One (To be completed/signed by Parent/Guardian)

Name (Last) _____ (First) _____ (MI) _____

Insurance Information

Provincial Medical Insurance Number _____ (MSI, etc.)

Is the camper covered by any additional insurance? _____ Yes _____ no

If yes, Insurance Company Name _____

Address _____

Telephone Number _____

Name of Insured _____

Relationship of Camper to insured _____

Plan Name, Group Number and Policy Number: _____

Emergency Treatment Release

I hereby authorize the medical personnel chosen by Atlantic Burn Camp to secure and administer treatment for my child in the event of a medical emergency. This treatment may include, but may not be limited to transportation, x-rays, routine tests and the necessary treatments.

Signature of Parent/Guardian _____

Date: _____

Health History

List any allergies the camper is known to have:

List any medications the camper is currently taking and dosage (* if medicines are to be sent to camp, they must be in their original container and submitted to the medical staff upon arrival at camp):

<u>Has the camper ever</u>	<u>YES</u>	<u>No</u>
1. Had any recent illness or injury?	_____	_____
2. Been exposed to a communicable disease?	_____	_____
3. Been hospitalized for reason other than injury?	_____	_____
4. Had a chronic or recurring illness or condition?	_____	_____
5. Had a head injury or been knocked unconscious?	_____	_____
6. Had recurring headaches?	_____	_____
7. Worn glasses or contacts?	_____	_____
8. Passed out, been dizzy or had chest pain after Exercise?	_____	_____
9. Had seizures?	_____	_____
10. Been diagnosed with any type of heart problem?	_____	_____
11. Had high blood pressure?	_____	_____
12. Had back or joint problems?	_____	_____
13. Been diagnosed with diabetes?	_____	_____
14. Been diagnosed with asthma?	_____	_____
15. Had emotional or behavioral difficulties For which professional help was sought?	_____	_____

Please explain any "Yes" answers to the previous questions:

I certify that my child has been vaccinated against:

Table with 4 columns: Vaccine Name, Yes, No, Vaccine Name, Yes, No. Rows include DTP, Polio, Tetanus/Diphtheria, Measles, Mumps, Rubella.

Please use this space to provide any information about your child's medical and mental history about which we should be aware. Please include any physical, emotional, behavioral mental health information.

Name of Family

Physician

Telephone Number :()

I certify that the health history provided above is correct and complete as far as I know. Unless otherwise noted below, my child has my permission to take part in all scheduled camp activities with no restriction.

Parent/Guardian

Signature: _____

Date: _____

I do not wish for my child to participate in the following activities:

Part Two (To be completed/signed by a Licensed Medical Professional)

Camper Name: _____

I have examined the above Atlantic Burn Camp participant.

Date of last examination: _____

In my opinion, the above camp applicant: _____ (is or is not) able to participate in an active camp program.

Health Recommendations/Restrictions

The applicant is under the care of a physician at this time for the following reasons:

Current Treatment Includes: _____

Known Allergies: _____

Description of any limitations or restrictions on camp activities:

Please provide us with any additional information for the Atlantic Burn Camp health care staff, which might prove to be beneficial: _____

Signature of Licensed Medical Professional _____

Please print name: _____

Title: _____

Telephone Number :(_____) _____

Date: _____