ATLANTIC BURN CAMP

Health Form for Children

Part One ***(To be competed/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):
____
____
____

Has the camper ever		YES	No
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:

	Yes	No		Yes	No
DTP	___	___	Measles	___	___
Polio	___	___	Mumps	___	___
Tetanus/Diphtheria	___	___	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 MedicalProfessional____

Please print name:____

Title: ____

Telephone Number :(_______) ____

Date: ____