

CAMP SUNRISE

2011 Medical Form



If your child has medical, behavioural or dietary considerations, it is important that you let Camp Sunrise know so that we can ensure he/she has the safest and most successful camping experience possible.

GENERAL INFORMATION

Surname _____ First Name _____ Gender _____

Date of Birth (dd/mm/yy) ___/___/___ Age _____ Care Card Number _____

Name of Physician _____ Phone Number of Physician _____

Medical History: Please check if the camper has experienced any of the following:

- | | | | |
|--------------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Severe Nosebleeds | <input type="checkbox"/> Toothaches |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Severe Stomach Aches | <input type="checkbox"/> Other _____ |

Does the camper have any other medical, emotional or behavioral conditions of which we should be aware? (Please attach additional pages if necessary)

Are the camper's vaccinations up to date? _____

What was the date of the camper's last tetanus shot? _____

HEAD LICE

In our efforts to provide the best possible experience for all campers, it is imperative that parent/guardian check their child for evidence of lice prior to coming to camp. Upon arrival to Camp Sunrise, as part of the registration process, each camper will be checked for lice and provided treatment if necessary.

PARENT(S)/GUARDIAN(S) INFORMATION

Full Name _____

Home Ph _____ Work Ph _____ Cell Ph _____

ALLERGIES

Please list all allergies of your child (food, medication, environmental, etc.)

- 1. Allergy _____
 Reaction _____ Severity _____
 Treatment Required _____
- 2. Allergy _____
 Reaction _____ Severity _____
 Treatment Required _____
- 3. Allergy _____
 Reaction _____ Severity _____
 Treatment Required _____

ADDITIONAL INFO

Does your child carry an Epi-pen? _____

If yes, does your child know how to use his/her Epi-pen? _____

Please indicate whether your child has any dietary restrictions, other than food already mentioned.

MEDICATIONS

Please list all medications the camper is presently taking (attach additional pages if necessary). With the exception of Epi-Pens and Asthma Puffers, all medications will be stored and dispensed by the Camp Health Care Provider. It is recommended that the camper's physician prepare a letter describing, in detail, the camper's condition, treatment and any unexpected problems that may arise from that condition.

- 1. Name of Medication _____ Reason for Treatment _____
 Dosage _____ When Taken _____
- 2. Name of Medication _____ Reason for Treatment _____
 Dosage _____ When Taken _____
- 3. Name of Medication _____ Reason for Treatment _____
 Dosage _____ When Taken _____

MEDICATIONS (OVER-THE-COUNTER)

Camp Sunrise maintains a small supply of over-the-counter medications including Tylenol, Ibuprofen, Cough Lozenges/Syrups, Gravol, and Benadryl. Do you give Camp Sunrise permission to dispense such medications to your child if deemed appropriate? Yes No