

KILCOO CAMP – MEDICAL FORM

This form must be at camp before your son(s) arrival, and in the possession of the medical staff. If insurance coverage is not indicated, you will be billed directly for services rendered by the camp physician &/or hospital. Please attach a photocopy of your son(s) insurance card in addition to the information below.

Ontario Health Insurance Number 10 digits (+ version code): _____ - _____ - _____ (____).
Other insurance coverage: Name of carrier - _____.
Insurance # _____.

Camper Information

Name:	Date of Birth:
Permanent Address:	
(number, street, city, province)	
Parent Home Phone #:	Work Phone #:
Parent Summer Phone #:	Alternate Phone #:
Family Physician:	Phone#:
Height:	Weight:
	Email:

In case of emergency, please contact: _____ @ _____.

(name) (phone)

Indicate medical issues for which your son has been treated:

<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Sleep Walking	<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Urinary Tract Infections
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Lactose Intolerance	<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> Other significant medical problems requiring full awareness of camp doctor and nurse (i.e.: ADD/ADHD)		

Allergies: none, foods, nuts, bee stings, medications, other (List details below)
 Epipen required: Yes, No. Camper carries own Epipen Yes, No.

Immunization: (Please check if immunization is current and give date of last immunization shot)

<input type="checkbox"/> Diphtheria _____,	<input type="checkbox"/> Pertussis _____,	<input type="checkbox"/> Polio _____,	<input type="checkbox"/> Measles _____,	<input type="checkbox"/> Tetanus _____.
(Date)	(Date)	(Date)	(Date)	(Date)

Give details of all positive responses, and of major or recent illnesses, operations, injuries or treatments. Give details of any other physical or emotional problems for which treatment may be necessary at camp. List all regular medications.

To the best of my knowledge, _____ (name) is in good health, free of communicable disease, and physically able to participate in all camp activities, except as noted above. In case of medical and/or surgical emergency, I hereby give permission to the physician &/or nurse selected by the camp director, to secure proper treatment (i.e. hospitalization, injections, transfusions, anesthesia or surgery as appropriately required) for my son.

I certify that the above information is accurate, and that I concur with the statements as described.

 (Signature of parent/guardian)

 (Date)