

Rock Lake United Church Camp, Inc. Camper /Counsellor Personal Health Form

The information on this form will be used at the direction of the camp health care staff to ensure care and attention is given to the health of the participant. All information is considered personal and confidential.

Name _____ Date of Camp Attending _____

Address _____

Birth Date _____ Gender _____ Height _____ Weight _____

Parents/Guardian's Name _____

Address if Different than Above _____

Home Phone _____ Business Phone and /or Cell Phone _____

Provide photocopy of Provincial Health Care Card with both 6 and 9 digit numbers visible

MB Health Service Number _____ PHIN _____

Subscriber's Name _____ Other Health Insurance _____

If the above is unavailable in an emergency please provide an alternate emergency contact below.

Name _____ Home Phone _____

Cell and/or Business Phone _____

Relationship to Camper _____

Parents please complete the remainder of the form

Camper's Swimming Level _____ Completion Date _____

The Waterfront has a designated swimming area that is roped off and is supervised by two qualified lifeguards. Does your child need a life jacket for swimming in the designated area? _____

Other comments or instructions related to the water front? _____

Does the camper wear medically prescribed ear plugs? _____

Is the camper on a special diet? _____

If female, has this person menstruated? _____ If not is she prepared? _____

Does camper wear glasses or contacts _____

Date of last tetanus vaccine _____

Please list any restrictions to camp activities _____

Check if the camper is currently subject to any of the following,

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Respiratory Diseases |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Motion sickness | <input type="checkbox"/> Ear Troubles |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Stomach Pain |
| <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Conditions |
| <input type="checkbox"/> Kidney/Bladder Problems | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Psychiatric Treatment |

Please specify below any other medical conditions and usual treatment of any conditions.

Does child wear a medic alert bracelet if so why_____

Does camper have any allergies? (Medication, Food, Environmental)_____

What is the reaction to allergies and how are they treated?_____

Has the camper had any recent illness or does the camper have any chronic condition_____

Is there anything that would help us provide better care to your child? (recent family changes, fears, shyness, behaviour challenges)_____

All medication, prescription or over the counter must be brought to camp in the original container and given to the first aid attendant on arrival. Prescription medication must have a label that indicates camper's name, name of medication, dose of medication, frequency, physicians name and date of prescription.

Medication	Dosage	Times to be given	Reason for Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please indicate any over the counter medications that may be given to your child at camp if needed:

Tylenol (Acetaminophen) ___yes ___no Motrin (Ibuprofen) ___yes ___no
 Gravol (Dimenhydrinate) ___yes ___no Antihistamine ___yes ___no
 Cough Syrup ___yes ___no

All information supplied will help care for your child while they are at camp. If medical care is required for your child you will be notified.

If your child needs to phone home they will be asked to phone collect.
All medical records are held for seven years then destroyed.

To the best of my knowledge, my child is in good health. I will notify the camp if my child is exposed to any infectious disease during the three weeks prior to camp. In the case of a medical emergency, I understand that every effort will be made to contact the parents or guardians. In the event that I can not be reached, I hereby give permission to the Physician selected by the Camp Coordinator and First Aid Attendant or designate to hospitalize, order x rays and routine tests, secure proper treatment including anaesthesia and surgery for my child as named above. I understand that in an emergency my child maybe transported in a personal vehicle and I hereby waive my right, and that of my child, to claim against Rock Lake United Church Camp, its employees or volunteers. This form may photocopied and shared with the selected physician. In the event medication, medical advice, treatment and/or equipment are required, I agree to accept financial responsibility in excess of the benefits allowed by Provincial Health and/or medical insurance. I give permission to administer the medications as listed above. I also give permission for routine medical care for my child at camp.

Signature of Parent or Guardian_____

Date_____

Medical Form must be completed within 30 days of the start of camp and be brought to camp