

# ARROWHEAD CAMP CAMPER HEALTH FORM

1111 Ronville Rd., RR#1, Dwight, ON P0A 1H0 Phone 705-635-1600 Fax 705-635-1630

Session attending: \_\_\_\_\_

ATTACH COPY OF ONTARIO  
HEALTH CARD HERE

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ONTARIO HEALTH CARD #: \_\_\_\_\_

NAME OF FAMILY DOCTOR \_\_\_\_\_ DOCTOR'S PHONE # \_\_\_\_\_

## EMERGENCY CONTACTS

1<sup>st</sup> Emergency Contact

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Work Number: \_\_\_\_\_ Home Number: \_\_\_\_\_

Cell: \_\_\_\_\_

2<sup>nd</sup> Emergency Contact

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Work Number: \_\_\_\_\_ Home Number: \_\_\_\_\_

Cell: \_\_\_\_\_

## MEDICAL HISTORY

If camper has had any of the following, please check (give dates if possible):

<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Measles, red	<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Hernia
<input type="checkbox"/> Measles, German	<input type="checkbox"/> Frequent earaches	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Fainting spells	<input type="checkbox"/> Frequent sore throat	<input type="checkbox"/> Sinus trouble
<input type="checkbox"/> Seizures	<input type="checkbox"/> Hayfever	<input type="checkbox"/> Mumps
<input type="checkbox"/> Severe stomach aches	<input type="checkbox"/> Heart condition	<input type="checkbox"/> High fever
<input type="checkbox"/> Whooping cough (recent)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other

Does the camper wear contact lenses?      YES      NO

Has your camper menstruated?      YES      NO

If no, has it been discussed? \_\_\_\_\_

## IMMUNIZATION

Please give most recent dates for the following immunizations:

DPT/Polio \_\_\_\_\_ Tetanus \_\_\_\_\_ Measles \_\_\_\_\_

### ALLERGIES

Please list any allergies to food, drugs, bee stings, etc:

\*\*\* If camper has a SEVERE LIFE-THREATENING ALLERGY  
**TWO** EPIPENS must be brought to camp\*\*\*

### DIETARY RESTRICTIONS

Please indicate if your camper requires vegetarian meals or has other dietary restrictions:

### MEDICATION

If there is any medication to be taken at Camp, state what medication is, what it is for, and how often it is to be administered.

THIS MEDICATION MUST BE BROUGHT TO CAMP IN ITS ORIGINAL BOTTLE OR PACKAGE AND GIVEN TO THE CAMP NURSE

MEDICATION	REASON	TIMES GIVEN

### TO BE SIGNED BY PARENT(S) OF CAMPER

To the best of my knowledge, my child is in good health and has not been exposed to any infectious diseases. If he/she is exposed to any infectious disease within two weeks preceding arrival at camp I understand that the camp must be notified. In case of an emergency and I/we are not available for consultation, I/we hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment, order injections, anesthesia, or surgery for my child, as named herein. I also grant permission to the Camp Nurse to administer prescription and non-prescription medications within recommended dosages if needed.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

*All information is kept private and confidential and adheres to the Privacy Policies of Arrowhead Camp. No information will be disclosed to a third party unless it is of a medical necessity. If you have any concerns about the Privacy Policies of Arrowhead Camp please contact the Camp and ask to speak to the privacy officer – Patrick Birnie.*