



Camper Last Name	First Name	Unit	Session
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CAMP WAHANOWIN CAMPER AND CIT HEALTH FORM

2010

(To be completed by parent or guardian)

The information provided within this health form is confidential between the camper's parents and the Camp Wahanowin Doctors, Nurses and Directors. The health centre staff or Directors however may release information to Unit Heads, counsellors or outside medical facilities if it is deemed to be in the best interest for the care of the camper.

This completed health form must be mailed to the city office prior to **June 18th**. Campers will not be allowed to attend camp if we do not have their health card number or health insurance numbers on file. Any medications will be collected at the bus departure location in Toronto or at camp for campers travelling from the airport or arriving from a destination outside Toronto.

Camper's Name (print): Last Name _____ Given Name _____

Date of Birth (Month/Day/Year): _____

Names of Father: (Dr./Mr.) _____ Mother: (Dr./Mrs./Ms.) _____

Home Address: _____

City: _____ Province/State: _____ Postal/Zip Code: _____

Home Phone #: () _____ Cottage/Summer #: () _____

Father's Work #: () _____ Mother's Work #: () _____

Father's Cell #: () _____ Mother's Cell #: () _____

Ontario Residents - please be sure that your Provincial Health Card Number information is complete.

Health Card Number: _____ Version Code: ____ (if applicable)

Out of Ontario Families - By providing my signature on the reverse side, I hereby agree that any matters arising from my stay at Camp Wahanowin or arising out of any medical attention or treatment I receive, including my relationship with any physician, nurse or hospital shall be governed by the laws of the Province of Ontario and I hereby submit to the exclusive jurisdiction of the courts of the Province of Ontario in that regard.

Your child's attendance at Camp Wahanowin and your relationship with Camp Wahanowin, its Directors, officers, employees, medical staff and agent shall be governed by the laws of the Province of Ontario and you shall submit to the exclusive jurisdiction of the courts of the Province of Ontario in that regard.

I acknowledge that any medical treatment will be performed in the Province of Ontario and that the Courts of Ontario shall have exclusive jurisdiction over any claim, legal dispute or cause of action relationship with a physician, nurse or hospital. I hereby agree that if I commence any such legal proceedings they will be held only in the Province of Ontario and I hereby irrevocably submit to the exclusive jurisdiction of the Courts of the Province of Ontario.

Health Insurance Plan and Number: _____

Billing Address: _____

In case of emergency (when parents are unable to be reached) please notify:

Name: _____ Relationship _____

Home Phone #: () _____ Business Phone #: () _____

Have you any special requests or directions (physical limitations, learning disabilities, behavioural problems, etc.) that you wish the camp health staff to note? _____

Height (feet/inches): _____

Weight (in pounds): _____

If camper has had any of the following please check ✓:

Scarlet Fever		Sinus Trouble		Appendicitis		Diabetes		Chicken Pox	
Frequent Colds		Sore Throats		Stomach Aches		Hernia		Measles	
Rheumatic Fever		Discharging Ear		Hay Fever		Asthma		German Measles	
Spells-any kind		Whooping Cough		Sleepwalking		Mumps		Heart Condition	
Toothaches		Bed Wetting		Past Operations:					

Please enter the date of *last* booster (this must be completed each year per OCA guidelines):

Diphtheria/Tetanus _____ Polio _____
 Whooping Cough (Pertussis) _____ Measles/Mumps/Rubella _____
 Tuberculin Test (and result) _____ Hib Vaccine (Hemophilus) _____
 Hepatitis A Vaccine _____ Hepatitis B Vaccine _____
 Varivax (Chicken Pox) Vaccine _____ Meningitis Vaccine _____

Indicate if this person is allergic to any of the following and specify as needed:

Penicillin: _____ Nuts: _____ Dairy: _____
 Animals: _____ Bee Stings: _____
 Drug Allergies (please specify): _____
 Additional allergies; food etc (please specify): _____

Are there any special medications or injections to be given during the summer Yes No
 If so, please state clearly when and how often they are to be administered _____

PLEASE NOTE - ANY MEDICATION SENT TO CAMP MUST BE IN ITS ORIGINAL BOTTLE OR PACKAGE!

Are there any other items of a medical nature that might arise during the summer? (ie. eating disorder) please specify _____

Has or is your child receiving psychological or group counselling or psychiatric help? Yes No
 If yes, please explain (attach a letter if necessary) _____

There has unfortunately been a lice problem in many schools in the past and sometimes campers inadvertently bring this nuisance into camp. **Please do a lice check on your child** now and again within 3 days of departure for camp. (If you do find lice, please notify the camp office)

Doctor's Name: _____ Telephone: () _____

If there is on-going medical supervision or care needed, a referral letter from your doctor would be helpful.

To the best of my knowledge this camper is in good health and is physically able to participate in all camp activities except as indicated. To the best of my knowledge I have provided all relevant medical information for my son/daughter's stay at camp.

The camp stocks common medications including many antibiotics for most medical conditions. Special medications or services will be charged back to your account if necessary.

In the event of an emergency and/or special medical treatment, parents will be notified immediately. If the parent's cannot be reached, permission is hereby given to Camp Wahanowin Limited to take whatever steps it deems necessary to ensure the safety and health of a camper. This also gives permission to the Camp to contact the emergency contact and/or the camper's family physician.

Signature of Parent/Guardian: _____ Date: _____