

# OLYMPIA HEALTH FORM 2011

# RETURN PRIOR TO ARRIVAL AT CAMP

Indicate which week and sport your child is attending

- ① July 3 -9 \_\_\_\_\_      ② July 10 - 16 \_\_\_\_\_      ③ July 17 - 23 \_\_\_\_\_  
④ July 24 - 30 \_\_\_\_\_      ⑤ July 31 - Aug 6 \_\_\_\_\_      ⑥ Aug 7 -13 \_\_\_\_\_  
⑦ Aug 14 - 20 \_\_\_\_\_      ⑧ Aug 21 - 27 \_\_\_\_\_      ⑨ Aug 28 - Sept 3 \_\_\_\_\_

**NAME OF CAMPER** \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_

**Address** \_\_\_\_\_ City \_\_\_\_\_ Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_

**HEALTH CARD #**

Immunization up-to-date \_\_\_\_\_ Date of last booster \_\_\_\_\_

**Name of Parent / Guardian** \_\_\_\_\_ **Home Phone #** \_\_\_\_\_

Work #

Cell #

Other #

## **CAMPER HEALTH HISTORY - Has your child experience any of the following:**

- |   |  |   |                                       |   |
|---|--|---|---------------------------------------|---|
| <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> Seasonal allergies  | <input type="checkbox"/> Tonsillitis        | <input type="checkbox"/> Bedwetting   | <input type="checkbox"/> Asthma           |
| <input type="checkbox"/> Red Measles    | <input type="checkbox"/> Frequent Colds      | <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Fainting     | <input type="checkbox"/> Diabetes         |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Ear trouble         | <input type="checkbox"/> Stomach aches      | <input type="checkbox"/> Homesickness | <input type="checkbox"/> Epilepsy         |
| <input type="checkbox"/> Mumps          | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Urinary Infections | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Heart Conditions |

**PLEASE USE BACK OF FORM** to explain health issues, emotional or physical limitations, learning disabilities, ADD, social challenges or other information to ensure camper's safe and healthy week. Include all medications camper is taking and treatments. Prescription medication must have camper's name, name of medication, dosage and time to be given on label. Medications brought to camp must be in the original packages.

**Medications must be handed to the Health Centre in a Ziploc bag, labelled with camper's name.**

## **ALLERGIC REACTIONS \*\*IMPORTANT\*\* Use back of form for explanation of Severity and Treatments**

- Allergic to Penicillin \_\_\_\_\_  Allergic to other medications \_\_\_\_\_
- Allergic to bees/ hornets/ wasps \_\_\_\_\_  Other insects \_\_\_\_\_
- Allergic to food \_\_\_\_\_  Other \_\_\_\_\_ **EPI-PEN** \_\_\_\_\_

## **DIETARY REQUIREMENTS**      VEGETARIAN      GLUTEN FREE      LACTOSE FREE

**Dietary Request - medical or religious reasons only:**

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 diseases during the three weeks prior to camp. In case of medical emergency, I understand every effort will be made to contact parents / guardians. In the event I cannot be reached, I hereby give permission to the physician selected by the Camp Director to secure treatment, hospitalize, order injections, anaesthesia or surgery for my child named above.

**Signature of Parent / Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

