CAMP KALALLA
PERSONAL HEALTH INFORMATION

Health Care at Camp Kalalla is based on the Ontario Camping Association Standards. Maintaining the health and safety of our campers and staff ensures that they may participate to the best of their abilities in the camp program. The following information must be completed in full **no later than 2 weeks prior** to the camp session in order to be admitted to camp. The information is confidential and used at the discretion of the Camp Health Care Worker and Camp Director to ensure proper health care is given to the participant.

PARTICIPANT INFORMATION

Name ___________________________________ Date of Birth____/____/____ Age at camp _____
Surname Given Name Day Month Year

Address _________________________________ City _____________ Postal Code _____________

Self-identifies as female _____ male _____ other _____

PARENT/GUARDIAN CONTACT INFORMATION

Contact #1 Name ___________________________ Relationship __________ Custodial Parent? Y / N

Email address ____________________________ Address ___________________________________

Phone: Home (___)________________ Work (___)________________ Cell (___)________________

Contact #2 Name ___________________________ Relationship __________ Custodial Parent? Y / N

Email address ____________________________ Address ___________________________________

Phone: Home (___)________________ Work (___)________________ Cell (___)________________

EMERGENCY CONTACT INFORMATION

Please designate an alternate who can be contacted if parents are not available. Please ensure emergency contact will be available for the duration of camp.

Emergency Contact _______________________ Relationship to participant ___________________

Phone: Home (___)________________ Work (___)________________ Cell (___)________________

PHYSICIAN CONTACT INFORMATION

Family physician ____ Phone (___)________________

Specialist and specialty ____________________________________ Phone (___)________________

HEALTH HISTORY

In order to provide the best health care, the following information is very important. Please attach more information, if needed. The camp program includes sleeping in cabins and tents, swimming, hiking, canoeing, kayaking, and overnight camping.

New All participants will be checked for head lice upon arrival. All participants must be nit/egg- and lice-free. If head lice and/or nits/eggs are detected, the participant must leave camp until 2 treatments have been given (7 to 10 days apart). Arrangements for possible return to camp will be at the Health Care Coordinator's discretion. In order to avoid the disappointment of missing camp, please check your camper's head regularly in the 2 weeks prior to camp in order to give time for proper treatment. If a second treatment is given immediately prior to camp, please inform the camp Registrar.
Please initial _____

Has the participant received a psychiatric diagnosis such as anxiety or depression? Yes / No
If yes, please explain ____
____

Does the participant have a learning disability? Yes / No
If yes, please explain ____
____

Has the participant received a diagnosis of Attention Deficit/Hyperactivity Disorder? Yes / No
If yes, please explain ____
____

Has the participant received a diagnosis of Autism Spectrum Disorder? Yes / No
If yes, please explain ____
____

Does the participant suffer from any physical disorder that would prevent her from fully participating in the camp program? Yes / No
If yes, please explain ____
____

Does the participant suffer from any emotional disorder that would prevent her from fully participating in the camp program? Yes / No
If yes, please explain ____
____

It is mandatory that height and weight be known for first aid/medication treatment.

Height __________ Weight __________

Has the participant been to overnight camp before? Yes / No

Is the participant a swimmer? Yes / No

Has the participant menstruated? Yes / No If not, has she been told about it? Yes / No

Are corrective lenses (glasses or contact lenses) required? Yes / No Hearing aids? Yes / No

Name: ________________________

RECENT ILLNESS, OPERATIONS, OR INJURIES

Please explain the condition and treatment/medications given. ______________________________

____

____

Will this condition limit of affect participation in activities? Yes / No If yes, please explain.

____

____

DIETARY REQUIREMENTS

Please note that participants who indicate special dietary requirements will be expected to follow that diet for the duration of camp.

Regular diet, as tolerated ______

Lactose-intolerant, managed by participant ______

Lactose-intolerant, requires lactose-free diet ______

Vegetarian ______ Please provide details ____

Gluten-free ______ Is there a medically confirmed diagnosis of Celiac disease? Yes / No

Other food restrictions? Please provide details ____

Has the participant ever been diagnosed with an eating disorder/disordered eating or displayed similar symptoms? Yes / No If yes, please explain.

____

____

MEDICALLY CONFIRMED ALLERGIES

Please state name of substance, reaction that occurs, severity of reaction (mild, medium, severe, life-threatening), and treatment given. Attach any pertinent information.

Drugs ____

____

Insect Stings ____

____

Seasonal Allergies (e.g., hay fever) ____

____

Other ____

____

Carries Epipen or Allerject auto-injector? Yes / No Wears Medic Alert? Yes / No

It is the policy of Camp Kalalla that participants carry their own auto-injector. Please send a carrying case for this purpose. Please send a second auto-injector to be kept in the Health Unit. If the allergy is severe/life-threatening, it is your responsibility to provide complete information.

Name: ________________________

IMMUNIZATION

Date of last DPT and polio booster _____ Date of last tetanus shot/booster (every ten years) _____
We have decided NOT to immunize our child _____

OTHER HEALTH ISSUES

Asthma ______
Bed wetting ______
Bleeding issues ______
Colds/sinus issues ______
Concussion ______
Diabetes ______
Earache/infections ______
Eating disorders ______
Hay fever ______
Headaches ______
Head lice ______
Heart disease/defect ______
Homesickness ______
Hypertension ______
Motion sickness ______
Nightmares ______
Physical limitations ______
Seizure disorders ______
Skin conditions ______
Sleepwalking ______
Urinary tract infection _____
Other, please specify ____
More detailed information on any of the above issues ______________________________________
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____

MEDICATIONS

All medications must be in **original containers and clearly labeled**. Please include information about the medication, if possible. Please send any non-prescription medications that participant may need (e.g. pain relief for headaches or menstrual cramps, antihistamines, etc.)

Does the participant take any other medication that will be discontinued while at camp? Yes / No
If yes, please explain. ____

Please list **all** medications. **All medications must be kept locked in the Health Unit.**

Name of Medication	Dosage	Administration Times	Reason for Taking	Requires Refrigeration
ex: Claritin, 10 mg	1 tab, once daily	8 am	allergies	no

PERMISSION TO ADMINISTER MEDICATIONS

I give permission for the Health Care Worker to dispense non-prescription medication without contacting me. Please check all that apply and sign below.

Acetaminophen (Tylenol) ______ Benadryl ______ Ibuprofen (Advil) ______

Antibiotic cream ______ Calamine lotion ______ Throat lozenges ______

I do not give permission ______

Parent/Guardian signature for participants under the age of 18 ________________________________

Name: ________________________

AUTHORIZATION

To the best of my knowledge, this participant does not have a communicable disease, has not been in contact with anyone who has a communicable disease within 3 weeks of the camp session start date, and is physically able to participate in all camp activities except as indicated. All medical problems or conditions requiring ongoing medical supervision or care have been fully noted. **Please initial** ______

I give permission for this health information to be shared with the appropriate camp staff and outside medical personnel as necessary. If the parent/guardian cannot be reached, permission is hereby given to the camp staff to take whatever steps it deems necessary to ensure the safety and health of the participant. Permission is also given for the camp to contact the participant's family physician/specialist. Please inform your family physician/specialist that you have given this authorization. **Please initial** ______

I hereby certify that all information in this form is accurate and up to date. I will contact the camp as soon as possible if any changes occur in the participant's health status. **Please initial** ______

Parent/guardian of participants **under** the age of 18, please print full name ____________________

Signature ______________________________ Date _________________________

OR

Participants **over** the age of 18

Signature ______________________________ Date _________________________

CAMP ADMISSION NOTES

For Camp Kalalla use only, please.

Date/Time ____________________________ Medications ________________________________

Head lice check _______________________ ________________________________

Auto-injector with carrying case? ________ ________________________________

Seen in Health Unit and appears to be in good health. Signature HCW _________________________

HEALTH NOTES - attach Supplementary record if necessary

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