Completing the staff health form

All health forms must be received by **July 1st** at health@kalalla.com. Information within the form is used to plan the food order, to influence staffing decisions, and requires additional work by the Health Team. Please respect the timeline so as not to cause more work than necessary to other camp staff and committee members.

Please complete the fillable PDF online and then submit by email. If necessary, a scanned copy can be sent by email. **Do not send photos of the form**.

How to scan documents with iPhone
https://support.apple.com/en-ca/HT210336

How to scan documents with Android phone
https://support.google.com/drive/answer/3145835?hl=en&co=GENIE.Platform%3DAndroid

Key points not to miss on the health form

*New for 2026 - there are separate health forms for staff and campers. Please ensure to complete the correct form.

Page 2

- The participant's name should be labeled at the top of each page
- Height and weight **must** be given. Do not submit the form without them.

Page 3

- Please indicate the correct diet. Participants will be expected to follow that diet for the entirety of camp. Choose only one option.
- Vaccination dates **MUST** be included. Do not submit your health form without them.

Page 4

- All medications must be sent in **original containers** and clearly labeled. Do not send medication in baggies or other generic containers.

Page 5

- For those under the age of 18, the Permission to Administer Medications must be signed.
- The four Authorization sections must be initialed.
- The form must be signed on the appropriate line.

CAMP KALALLA *STAFF*
PERSONAL HEALTH INFORMATION

Health Care at Camp Kalalla is based on the Ontario Camps 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 July 1st** in order to assure admission 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.

STAFF INFORMATION

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

Address _____ City _____ Postal Code _____

Email _____ Phone _____

Camp Name (if known) _____

PARENT/GUARDIAN CONTACT INFORMATION (FOR STAFF 17 AND UNDER)

Contact Name _____ Relationship _____

Custodial Parent? Y ◯ N ◯ Email _____

Address (if different from above)_____

Phone 1: _____ Phone 2: _____

Contact Name _____ Relationship _____

Custodial Parent? Y ◯ N ◯ Email _____

Address (if different from above)_____

Phone 1: _____ Phone 2: _____

EMERGENCY CONTACT INFORMATION

Please designate an alternate who can be contacted in an emergency. Please ensure the emergency contact will be available for the duration of camp.

Emergency Contact _____ Relationship to participant _____

Phone 1: _____ Phone 2: _____

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, hiking, swimming, canoeing, kayaking, and overnight camping.

Please share any physical, emotional, or mental health disorders that would be relevant to the participant's time at camp.

_____

Please share any relevant information regarding the participant's sex or gender identity.

_____

Is the participant a swimmer? Yes ◯ No ◯ Please note any condition that might cause a safety issue when swimming/boating (e.g., seizures)

_____

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

Height _____ Weight _____

RECENT ILLNESS, OPERATIONS, OR INJURIES

Please explain the condition and treatment/medications given.

_____

Will this condition limit or affect participation in activities? Yes ◯ No ◯ Please explain.

_____

OTHER HEALTH ISSUES/EQUIPMENT

Asthma _____	Earache/infections _____	Motion sickness _____
Bed wetting _____	Cochlear implant _____	Nightmares _____
Bleeding issues _____	Hearing aids _____	Orthodontia _____
Concussion _____	Headaches/migraines _____	Pacemaker _____
Diabetes _____	Heart disease _____	Seizure disorders _____
Continuous glucose monitor ____	Homesickness _____	Skin conditions _____
Insulin pump _____	Hypertension _____	Sleepwalking _____

More detailed information on any of the above issues

_____

DIETARY REQUIREMENTS

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

Regular diet _____

Lactose-intolerant, self-managed (regular diet) _____ **OR** requires lactose-free diet _____

Vegetarian _____ Details _____

Gluten-free _____ Is there a medically confirmed diagnosis of Celiac disease? Yes ○ No ○

Other food intolerances? Please provide details _____

Has the participant been diagnosed with an eating disorder or displayed similar symptoms?

Yes ○ No ○ Please explain.

_____

MEDICALLY CONFIRMED ALLERGIES

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

Drugs _____

Food _____

Insect Stings _____

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

Other _____

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.

Carries auto-injector? Yes ○ No ○

IMMUNIZATION

Participants **17 and under**:

It is the policy of Camp Kalalla that all participants aged 17 and under must meet the requirements of Ontario Immunization of School Pupils Act.

Participants **18 and older**:

It is the policy of Camp Kalalla that all participants 18 and over must have had two doses of the measles, mumps and rubella vaccine (or proof of immunity) and an up-to-date tetanus shot/booster. We strongly encourage adult participants to verify that all of their other vaccines are up to date as well.

Date of most recent: DPT and polio booster _____

(both dates required) MMR vaccinations _____ AND _____

Tetanus shot/booster (every ten years) _____

MEDICATIONS

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

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 (FOR PARTICIPANTS 17 AND UNDER)

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) _____ Cetirizine (Reactine) _____ Ibuprofen (Advil) _____

Antibiotic cream _____ Throat lozenges _____

I do not give permission _____

Parent/Guardian signature for participants 17 and under _____

PLEASE SHARE ANY OTHER INFORMATION YOU FEEL IS RELEVANT TO YOUR WELL-BEING AND SUCCESS AT CAMP

AUTHORIZATION

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 Team's discretion. In order to avoid the disappointment of missing camp, please check your 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 _____**

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 emergency contact 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. **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, print full name _____

Signature _____ Date _____

OR

Participants aged 18 and over

Signature _____ Date _____

CAMP ADMISSION NOTES

For Camp Kalalla use only.

Date/Time _____ Auto-injector _____ Head lice check _____

Medications

_____

_____

_____

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

_____

HEALTH NOTES - attach Supplementary record as necessary

_____

_____

_____

_____

_____