CAMP KALALLA
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.

## PARTICIPANT INFORMATION

Name _____ Date of Birth_____ Age at camp _____
Surname Given Name Mmm-dd-yyyy

Address _____ City _____ Postal Code _____

*Staff only* Email _____ Phone _____

Self-identifies as female ◯ male ◯ other ◯

## PARENT/GUARDIAN CONTACT INFORMATION

Contact #1 Name _____ Relationship _____ Custodial Parent? Y ◯ N ◯

Email _____ Address _____

Phone: Home _____ Work _____ Cell _____

Contact #2 Name _____ Relationship _____ Custodial Parent? Y ◯ N ◯

Email _____ Address _____

Phone: Home _____ Work _____ Cell _____

## EMERGENCY CONTACT INFORMATION

Please designate an alternate who can be contacted if parents are not available. Please ensure the 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, hiking, swimming, canoeing, kayaking, and overnight camping.

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 diagnosis of:

| | |
|---|---|
| Anxiety or depression | Yes ◯ No ◯ |
| Learning disability/disorder | Yes ◯ No ◯ |
| Attention Deficit/Hyperactivity Disorder | Yes ◯ No ◯ |
| Autism Spectrum Disorder | Yes ◯ No ◯ |

Does the participant have any physical disorder that would prevent her from fully participating in the camp program? Yes ◯ No ◯

Does the participant have any emotional disorder that would prevent her from fully participating in the camp program? Yes ◯ No ◯

More information on any of the above:

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 ◯

Please note any condition that might cause a safety issue when swimming/boating (e.g., seizures)

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

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

RECENT ILLNESS, OPERATIONS, OR INJURIES
Please explain the condition and treatment/medications given.

Will this condition limit or 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 ☐

Lactose-intolerant, managed by participant (regular diet) ☐ OR requires lactose-free diet ☐

Vegetarian ☐ Please provide details

Gluten-free ☐ Is there a medically confirmed diagnosis of Celiac disease? Yes ◯ No ◯

Other food allergies? Please provide details

Has the participant been diagnosed with an eating disorder 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 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.

## 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. It is also strongly recommended that participants have as many of the Covid-19 vaccines for which their age group is eligible.

Participants 18 and older:

It is the policy of Camp Kalalla that all participants 18 and over must have had two doses of 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. It is also strongly recommended that participants have as many of the Covid-19 vaccines for which their age group is eligible.

Date of most recent: DPT and polio booster _____

MMR vaccination _____

Tetanus shot/booster (every ten years) _____

Covid-19 vaccination or booster _____

## OTHER HEALTH ISSUES

| | | | | | |
|---|---|---|---|---|---|
| Asthma | ☐ | Hay fever | ☐ | Nightmares | ☐ |
| Bed wetting | ☐ | Headaches | ☐ | Physical limitations | ☐ |
| Bleeding issues | ☐ | Head lice | ☐ | Seizure disorders | ☐ |
| Colds/sinus issues | ☐ | Heart disease/defect | ☐ | Skin conditions | ☐ |
| Concussion | ☐ | Homesickness | ☐ | Sleepwalking | ☐ |
| Diabetes | ☐ | Hypertension | ☐ | Urinary tract infection | ☐ |
| Earache/infections | ☐ | Motion sickness | ☐ | Other (details below) | ☐ |

More detailed information on any of the above issues

## 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 participants 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 note the medication and 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) ☐ | Cetirizine (Reactine) ☐ | Ibuprofen (Advil) ☐ |
| Antibiotic cream ☐ | Calamine lotion ☐ | Throat lozenges ☐ |

I do not give permission ☐

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

Typing your name represents your signature

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 _____

Typing your name represents your signature

OR Participants aged 18 and over

Signature _____ Date _____

Typing your name represents your signature

**Reminder: please submit this form directly to health@kalalla.com.

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CAMP ADMISSION NOTES

For Camp Kalalla use only, please.

Date/Time _____ Head lice check _____

Auto-injector with carrying case? _____

Medications

_____

_____

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

HEALTH NOTES - attach Supplementary record if necessary

_____

_____

_____