Medical Form

Surname _____ **First Name** _____ **Initial** _____
DOB: _____**(dd/mm/yyyy) Care Card No.**_____
Address _____**City**_____
Province _____**Postal Code**_____
Email _____**Phone (h)** _____**(c)**_____
Doctor _____ **Doctor's Phone** _____

Allergies: _____
_____
_____

Medications: _____
_____
_____
_____

Treatments Required: _____
_____
_____

Restricting Conditions: _____
_____
_____
_____

Please circle yes or no for the following questions:

Does the camper carry an ANA Kit**?** Yes No

Does the camper know how to use the ANA Kit? Yes No

Does the camper carry and Epipen? Yes No

Does the camper know how to use the Epipen? Yes No

Does the camper carry and Medic Alert Bracelet? Yes No

Conditions (please circle any that pertain to your child)

Ear Aches	Head Aches	Stomach Aches	Sore Throat
Sinus Infection	Depression	Emotional concerns	Homesickness
Sleepwalking	Bedwetting	Eating disorders	Diabetes
Bronchitis	Arthritis	Seizures	Skin Conditions
Heart Conditions	Bleeding Disorder	Asthma	ADD/ ADHD

Fetal Alcohol Syndrome

Other: _____

All Immunizations: Yes No

In no, please explain: _____
_____
_____

*Date of last tetanus _____(dd/mm/yyyy)
Or ☐Tetanus shot received or date unknown

Hospitilization or communicable diseases: _____
_____
_____

Additional Notes: _____
_____
_____

Permission to give over-the-counter meds: Yes No

Expire Health Info: Yes No

Name: _____ Date: _____

Signature:_____