ONONDAGA CAMP

2017 CAMPER/LIT HEALTH HISTORY

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Please be as thorough as possible as this information is to be shared with the Camp Nurse/Doctor, Directors and specific counsellors involved with your child. The camp must be notified of any change in health status from the time this form is completed until the camper/LIT starts camp. Please attach a copy of immunization record to this form.

Session: _____

Camper/LIT Name (first & last)**:** _____ **Date of Birth:** month / day / year

Health Card # (optional): _____ version code: _____ Expiry Date: month / day /year

If the camper does not have a current Ontario Health Card a copy of their medical insurance must be attached to cover any medical care outside of camp.

Home Address: _____

Street City Province Postal/Zip Code Country

Custody/Living Arrangements: ☐ Both Parents ☐ Shared Custody ☐ Sole Custody

Parent #1	**Parent #2**
Name:_____ Relationship:_____	Name:_____ Relationship:_____
Cell #:_____ Home #:_____	Cell #:_____ Home #:_____
Business #:_____ ext: _____	Business #:_____ ext: _____

Emergency Contact (if parents cannot be contacted):

Name:_____Relationship:_____

Cell #:_____ Home #:_____ Business #:_____

Family Physician Information:

Name (first & Last):_____ Phone #: _____ ext:_____

Are all immunizations up to date (ie. Diphtheria, tetanus)? ☐ Yes ☐ No

Last Date of Tetanus Toxoid: month/ year

My child wets the bed: ☐ Yes ☐ No

If yes, would you like your child woken up once after bedtime to use the washroom? ☐ Yes ☐ No

Females Only: Has she menstruated? ☐ Yes ☐ No

If no, has she been told about menstruation? ☐ Yes ☐ No

Please indicate if your camper/LIT has had any of the following:

☐ Chicken Pox	☐ Appendectomy	☐ Mumps	☐ Measles – Red	☐ Diabetes	☐ Mononucleosis
☐ Hepatitis	☐ Measles – German	☐ Tonsillitis	☐ Heart condition	☐ Rheumatic Fever	☐ Seizures
☐ Asthma	☐ Whooping Cough	☐ Sinusitis	☐ Kidney Disease	☐ Sleep walking	☐ Hay Fever
☐ Fainting	☐ Sun Sensitivity	☐ Eczema	☐ Eating Disorder	☐ Tuberculosis	
☐ Operation(s) recent		☐ Serious Injury (recent)		☐ Ear infections (frequent)	

Please give details of the above:

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Anaphylactic Allergies:

Does the camper have any Anaphylactic (life threatening) allergies? ☐ Yes ☐ No

If yes, please list the anaphylactic allergy:_____ Date of last reaction: month / year

Other Allergies (a separate Allergy Form must also be completed for all serious allergies):

Please check all that apply:

☐ Food: ☐ Nuts/Peanuts/Tree nuts ☐ Dairy ☐ Other Food – Please specify: _____
☐ Drugs/Medication – Please specify: _____
☐ Environmental (hay fever etc.)
☐ Latex (balloons, gloves, band aides etc.)
☐ Animals – Please specify: _____
☐ Insects – Please specify: _____
☐ Other – Please specify: _____

Dietary Requirements:

☐ Regular, diet as tolerated
☐ Lactose-Intolerant
☐ Vegetarian: ☐ Semi-Vegetarian (no beef or pork) ☐ Lacto-Ovo (no beef, pork, chicken, seafood or fish)
☐ Vegan (no meats, eggs or dairy) ☐ Other – Please specify: _____
☐ Gluten Free Diet If yes, is there a medically confirmed diagnosis of Celiac? ☐ Yes ☐ No
☐ Other food restrictions – Please specify: _____

Has the camper ever been diagnosed with an Eating Disorder/ Disordered Eating or displayed similar symptoms? ☐ Yes ☐ No If yes, please explain: _____

Emotional, Social and Mental Health History:

Detailed answers to these questions will assist us in making your camper's stay at camp safe and successful; if you require more space for specifications, please attach another page.

Has the camper received a diagnosis of Attention Deficit Disorder (ADD) or ADHD? ☐ Yes ☐ No
Has the camper received a psychiatric diagnosis, such as depression, OCD, or panic/anxiety? ☐ Yes ☐ No
If yes, please specify: _____
Does the camper see a professional to address mental/emotional concerns? ☐ Yes ☐ No
If yes, please specify: _____
Has the camper required counseling for emotional, behavioural or mental health concerns? ☐ Yes ☐ No
If yes, please specify: _____
Does the camper have a learning disability? ☐ Yes ☐ No If yes, please specify:

_____

Does the camper have any physical disabilities? ☐ Yes ☐ No If yes, please specify:

_____

Are there any restrictions to activities or any accommodations required for full participation in the camp program? ☐ Yes ☐ No If yes, please specify what adaptations or limitations may be necessary:

_____

Other Relevant Information:

Is there anything that has not been covered that you would like to share with us (eg. Recent illness of a family member, change in family situation)?

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Medication:

Does the camper currently take any medication (including non-prescription drugs) at home on a regular basis? ☐Yes ☐No If yes, please specify: _____

List any medications that will be discontinued while at camp: _____

PLEASE NOTE: All medication must be in the original container or pharmacy issued blister pack. Non-prescription medications must also be in the original container with proper labeling. Please bring/send enough medication to last the entire time at camp. All medication, vitamins, etc., must be turned over to the Health Centre.

Please use the chart below to list any prescription and/or non-prescription medication or treatments to be given while at camp:

Name of Medication/ Treatment	**Dose** (amount)	**Route** (method med is taken by)	**Time(s)** (taken each day)	**Reason** (for taking /diagnosis)	**Special Instructions**
Eg. EpiPen, Salbutamol, Risperdal	Eg. 2 puffs inhaler, 1.5 mg pill	Eg. By mouth	Eg. As needed, 8am	Eg. Asthma, ADHD	Eg. Crushed, with apple sauce

To the best of my knowledge, this camper/LIT is in good health and has not been exposed to any infectious disease in the past four weeks. If he/she becomes exposed to any infectious disease between now and the time of departure for Camp or has any change in medical health, I will inform the Camp in writing prior to his/her arrival at Camp. In the case of surgical emergency, and we are not immediately available for consultation, I hereby give permission to the physician selected by the Director to hospitalize, secure proper treatment for and to order injections, anesthesia or surgery for the above-named child. I also authorize any physician currently treating my child or who has treated my child in the past or any other hospital or institution in which my child has received treatment to release any medical information concerning my child's previous or current medical history or condition to the Directors of the Camp and/or any physician selected by them to treat my child pursuant to the authorization given herein. I hereby agree that any matters arising out of my child's stay at Onondaga Camp or his/her medical treatment, including any relationship with a physician or hospital, shall be governed by the laws of the Province of Ontario and I hereby submit to the exclusive jurisdiction of the courts of the Province of Ontario in that regard.

_____ _____

Signature of Parent/Guardian Date