



# CAMPER HEALTH REPORT – 2010

**PLEASE NOTE:** This form **DOES NOT** need to be completed by a physician. Fill in the Health Report **NO EARLIER THAN 30 DAYS BEFORE THE CAMPER'S STAY** at camp and **MAIL TO:** Camp Nutimik, Box 68, Seven Sisters, MB R0E 1Y0.  
(Please Print)

Camper's First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

Postal Code \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Personal Medical # (9 Digits) \_\_\_\_\_ Registration # (6 Digits) \_\_\_\_\_

Other Medical/Accident Insurance Type & No. \_\_\_\_\_

Camp Name \_\_\_\_\_ Camp Dates \_\_\_\_\_

**In Case of Emergency:**

Guardian's Name \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_

Alternate Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_

Camper's Doctor \_\_\_\_\_ Phone # \_\_\_\_\_

Camper's Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

**General Health History (List any):**

**Indicate Treatment (i.e. give Tylenol, rest, etc.)**

<b>Chronic Illness</b> (i.e. diabetes, arthritis)	
<b>Psychological conditions</b> (i.e. ADD, behavioural concerns, phobias, depression)	
<b>Neurological conditions</b> (i.e. epilepsy, migraines, frequent headaches)	
<b>Eye problems</b> (i.e. pink eye, wears glasses / contacts)	
<b>Ear, Nose and Throat problems</b> (i.e. ear aches, sinusitis, sore throat)	
<b>Mobility Limitations</b>	
<b>Orthopedic Injuries/problems</b> (i.e. joint or back injuries)	
<b>Respiratory problems</b> (i.e. frequent colds or coughs)	
<b>Asthma</b> (what triggers an attack?)	
<b>Gastrointestinal problems</b> (i.e. stomach aches, nausea, vomiting, constipation)	
<b>Skin conditions</b> (i.e. rashes, eczema, hives, burns easily in the sun)	
<b>Past Surgeries</b>	
<b>Other</b> (i.e. Sleep walking, bed wetting)	

Are there any other medical conditions the Camp Nurse should be aware of?  Yes  No (If yes, please specify)

\_\_\_\_\_

**Girls Only:** Is she menstruating?  Yes  No

Is she aware of its possible onset?  Yes  No

Date of last physical exam \_\_\_\_\_

Date of last Tetanus shot \_\_\_\_\_

Are Immunizations up to date?  Yes  No

**Allergies** Please list any allergies to food (e.g., lactose intolerance), medication or other allergies (such as pollen, dust, etc.):

<u>Allergy</u>	<u>Reaction</u>	<u>Treatment (e.g. Epipen)</u>

**Medications**

Please list the medications that the camper is currently taking:

<u>Name of Medication</u>	<u>Dose</u>	<u>Time usually taken</u>	<u>Reason</u>

Has the camper been on any other medications in the last 4 weeks?  Yes  No (If yes, please specify):

If your child should become ill or injured while at camp, it may be necessary to give them medications that are administered by the camp nurse. The following is a list of medications available at the nursing station. Medications may include, but are not limited to this list. Please check off any medications you **DO NOT** want your child to receive.

- |  |  |
|--|--|
| <input type="checkbox"/> Tylenol (acetaminophen) – for pain/fever  | <input type="checkbox"/> Ibuprofen (Advil, Motrin) – for pain/fever        |
| <input type="checkbox"/> Lozenges (Halls, Cepacol) – for sore throats                                      | <input type="checkbox"/> Antacids (Tums, Rolaids) – for stomach ache       |
| <input type="checkbox"/> Gravol – for nausea or vomiting   | <input type="checkbox"/> Antibiotic Ointment (Polysporin) – for minor cuts |
| <input type="checkbox"/> Eye Drops (Visine or Polysporin) – for dry/red eyes                               | <input type="checkbox"/> Ear Drops (Polysporin) – for swimmers ear         |
| <input type="checkbox"/> Antihistamines (Benadryl, Claritin, Chlortripolon) – for allergy or cold symptoms |  |
| <input type="checkbox"/> Decongestants (Cough Syrup, Tylenol Cold) – for coughing/cold symptoms            |  |

**Please note:** All prescribed medication must be sent in the ORIGINAL PRESCRIPTION BOTTLE (please send sufficient supply with a few extra). The Camp Nurse will administer ALL medications. If the medication is not in the original bottle or the label is not legible **IT WILL NOT BE ADMINISTERED**. If any change in the camper’s health occurs prior to coming to camp, the camp must be notified.

Any over-the-counter medication must be in the ORIGINAL PACKAGE and be accompanied by parent instruction.

Has the camper had head lice and / or nits in the past year?  Yes  No If yes, please specify dates \_\_\_\_\_

\*Please note that the Nurse assisted by camp staff do a thorough lice check at the beginning of each camp session. Any camper found with head lice and / or nits will be sent home immediately for treatment. The camper may return to camp when diagnosed by a Public Health Nurse in writing to be lice and nit free.

If the camper has been exposed to an infectious disease or serious illness within the past six weeks, or has had a medical problem, please have your doctor send a letter to Camp Nutimik outlining the illness, physical activity restrictions and medications prescribed.

NOTE: In the event of serious illness, accident, or other emergency, parents / guardians will be contacted. In the event that the parents / guardians cannot be reached, I hereby give consent for the camp administration to arrange for professional medical treatment in the event of an emergency. In the event medication, medical advice, treatment, ambulance, and or equipment are required, the charges will be made to the parents / guardians.

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_