

# WILVAKEN

## Personal Health Form

A medical examination should be performed prior to arrival at *Wilvaken* **only** if your child has a chronic illness or allergy, or is receiving medical treatment.

**To help us care for your child, please advise us on an attached note if there is a recent change in marital status, family death, or any other such circumstance about which we should be aware. Explain adequately, and indicate who is the legal guardian of the child.**

The completed form should then be returned by mail to **Wilvaken: P.O. Box 741, Hudson Heights, PQ, J0P 1J0 before June 15<sup>th</sup> or 241 ch. Willis, Magog, PQ, J1X 3W2 after June 15<sup>th</sup> or before the beginning of your child's session.** Information on this form will be used at the discretion of the camp director(s) or nurse to ensure appropriate care and attention to the health of the camper.

☺ ☺ PLEASE PRINT ☺ ☺

I. To be completed by parent or guardian.

Period of enrolment: FROM \_\_\_\_\_ TO \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_

Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Height: \_\_\_\_\_ Weight \_\_\_\_\_ Medical Insurance No. \_\_\_\_\_ / \_\_\_\_\_  
SURNAME GIVEN NAME M/F  
YEAR / MONTH / DAY QUEBEC RESIDENTS ONLY EXP. DATE

Address \_\_\_\_\_  
NO. & STREET APT. NO. P.O. BOX/R.R. NO.

City \_\_\_\_\_ Province \_\_\_\_\_ Country \_\_\_\_\_ Postal Code \_\_\_\_\_  
CITY PROVINCE COUNTRY POSTAL CODE

Mother \_\_\_\_\_ Maiden Name \_\_\_\_\_  
SURNAMEFI FIRST NAME

Father \_\_\_\_\_  
SURNAME FIRST NAME

**Mother:** (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
HOME SUMMER CELLULAR BUSINESS

**Father:** (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
HOME SUMMER CELLULAR BUSINESS

If the above are unavailable in emergency please notify:

1. \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
SURNAME FIRST NAME HOME BUSINESS

2. \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
NO. & STREET APT. NO./P.O. BOX/R.R. NO. CITY COUNTRY POSTAL CODE CELLUAR

Name of Family Physician \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
NO. & STREET APT. NO./P.O. BOX/R.R. NO. CITY COUNTRY POSTAL CODE CELLUAR

### PARENT'S AUTHORIZATION

**IMPORTANT** This section *must be completed* by parent or legal guardian for attendance.

The person named above has permission to participate in all camp activities with the exception of \_\_\_\_\_ as noted by the examining physician and me.

I hereby give permission to the physician selected by the camp director to order routine tests, treatment, and X-rays for the health of my child. If I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure medical treatment for, and to order injection, anaesthesia or surgery for my child (or ward) as named above.

I also hereby give permission for the camp nurse/first aid attendant to administer over the counter medication if needed.

*I am aware and understand that Wilvaken does its best to protect against exposure to peanut and other allergic products where there are allergies of which I have given camp advance written notice. I know that Wilvaken is not a peanut free environment.*

I agree to accept financial responsibility in excess of the benefits allowed by provincial or other health insurance plans.

**To the best of my knowledge the information included in this medical form is correct and complete.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_  
SURNAME GIVEN NAME

**II. Health History - To be completed by parent or guardian.**

**IMPORTANT-** The camp must be notified should your child be exposed to any communicable diseases in the 3 weeks prior to the commencement of his/her session.

Is the participant currently subject to:			Has s/he had:			Received vaccination for:		
	YES	NO		YES	NO		YES	NO
HEADACHES			MEASLES					
BEDWETTING			MUMPS					
SLEEPWALKING			RUBELLA					
NIGHTMARES			WHOOPIING COUGH					
MOTION SICKNESS			CHICKEN POX					
EPILEPSY/SEIZURES								
ASTHMA			Date of last Anti-tetanus vaccination _____					

Chronic illness (specify) \_\_\_\_\_ Allergies (specify) \_\_\_\_\_

**Does your child carry an Epi-pen? YES / NO - If YES, do you give the camp permission to administer this medication in case of emergency YES / NO - Please sign X \_\_\_\_\_**

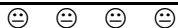
Is your child a vegetarian YES / NO *Wilvaken will serve vegetarian meals to those campers who are full time vegetarians. Vegetarians means no meat but includes all other foods.* Any other special dietary needs (specify) \_\_\_\_\_

Are glasses required: YES / NO Contact lenses: YES / NO Orthodontic appliances: YES / NO

**For female participants:**  
 Has she menstruated: YES / NO If **YES**, is her history normal: YES / NO \_\_\_\_\_  
 If **NOT**, has she been told about it: YES / NO \_\_\_\_\_

Is there any physical or emotional condition of which we should be aware for proper care of your child? If so, please state particulars (attach note if necessary): \_\_\_\_\_

LIST MEDICATION BEING TAKEN AT THIS TIME		
MEDICATION	DOSAGE	FREQUENCY



**III. Medical examination – To be completed by a doctor only if there is a chronic illness, allergy or on-going medical treatment.**

The bearer of this form wishes to participate in a camp program which includes strenuous activities such as swimming, horseback riding, sailing, canoeing, camping trips, etc. Examination is to determine whether the applicant is physically fit to participate in such a program.

PHYSICAL EXAM					
	NORMAL	ABNORMAL		NORMAL	ABNORMAL
EYES			ABDOMEN		
EARS			SPINE		
NOSE			REFLEXES		
THROAT			SKIN		
LUNGS			FEET		
HEART					

GENERAL APPRAISAL / OBSERVATIONS ON ANY ABNORMALITIES \_\_\_\_\_

Recommendations and/or restrictions \_\_\_\_\_

I have examined the person herein described. It is my opinion that this person is fit to participate in all camp activities  
 WITHOUT RESTRICTIONS  WITH RESTRICTIONS AS NOTED ABOVE

DATE \_\_\_\_\_ NAME OF DOCTOR \_\_\_\_\_ TELEPHONE \_\_\_\_\_

SIGNATURE OF EXAMINING DOCTOR \_\_\_\_\_ ADDRESS \_\_\_\_\_