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, QC, J0P 1J0 *before June 1st* or 241 ch. Willis, Magog, QC, J1X 3W2 *after June 1st or before the beginning of your child's session***. *You may fax or email the form. 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 _____
SURNAME GIVEN NAME M/F

Birthday_____/_____/____ Height:____Weight____Medical Insurance No._____/_____
YEAR / MONTH / DAY QUEBEC RESIDENTS ONLY EXP. DATE

Address_____
NO. & STREET APT. NO. P.O. BOX/R.R. NO.

_____
CITY PROVINCE COUNTRY POSTAL CODE

Mother _____ Maiden Name _____
SURNAME 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

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

2. _____ ☎ (_____)_____ (_____)_____
SURNAME FIRST NAME HOME BUSINESS

_____ (_____)_____
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. *I will inform the camp of any changes to my child's state of health between now and his / her arrival at Camp Wilvaken.*

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					
BED WETTING				MUMPS					
SLEEPWALKING				RUBELLA					
NIGHTMARES				WHOOPING 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 <u>full time</u> vegetarians. Vegetarians means <u>no meat</u> 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