

# Camp Ekon Medical Form

Year: \_\_\_\_\_ Camper's Name: \_\_\_\_\_  
Sex: \_\_\_\_\_

Date of Birth (M/D/Y): \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade Next Fall: \_\_\_\_ Height: \_\_\_\_  
Weight: \_\_\_\_  
Health Insurance Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

*All Campers must be covered by OHIP or equivalent*

## Home Address

Street: \_\_\_\_\_  
City: \_\_\_\_\_  
Postal Code: \_\_\_\_\_ Province: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Father's/Guardian's Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Mother's/Guardian's Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

## Past Medical History

Surgery?            Y        N        If yes, please explain: \_\_\_\_\_

Hospitalizations?    Y        N        \_\_\_\_\_

## Please circle if the camper has any of the following medical conditions:

Asthma            Diabetes            Seizures            Life-threatening allergies

*If circled, additional protocols/information must be completed*

Other special physical/emotional needs or other information of use to the camp physician/RN: \_\_\_\_\_

## Current Medications/Treatments:

## Allergic Reactions:

Food: \_\_\_\_\_ Bee Stings: \_\_\_\_\_ Nuts: \_\_\_\_\_ Other: \_\_\_\_\_

Type of reaction: \_\_\_\_\_

*If anaphylactic, additional protocols/information must be completed*

Have the following vaccines and toxoids been given and are up to date?

Diphtheria    Tetanus  
Polio            Tetanus Booster    Yes, the following vaccines and toxoids have been  
given  
MMR            Hepatitis A            and are up to date:

## Physician Contact Information

Name: \_\_\_\_\_ Street: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

# Camp Ekon Medical Form

Meningitis      Hepatitis B  
TB Test Result (LIT 2 Only): \_\_\_\_\_

To the best of my knowledge, my child is in good health and is physically and mentally able to participate in all camp activities, except as previously noted. I will notify the camp if my child has been exposed to an infectious disease during the three weeks prior to arriving at camp. I give permission for the camp director or his/her designate to contact my child's physician to obtain medical information when necessary. In the case of emergency, I understand that every reasonable effort will be made to contact parents or guardians. In the event that I cannot be reached, I hereby give permission to the camp physician selected by the camp director or his/her designate to hospitalize, secure proper treatment, order injection, anesthesia, or surgery for my child named herein.

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

\_\_\_\_\_

**We recommend that your child's physician review and sign this form.**

To the best of my knowledge, this child is in good health and is physically and mentally able to participate in all camp activities, except as previously noted.

## Physician Contact Information

Name: \_\_\_\_\_ Street:

\_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code:

\_\_\_\_\_  
Office Phone: \_\_\_\_\_ Physician Signature:

\_\_\_\_\_