



Community of Christ
Canada West
Mission Centre

Medical Information This medical information is required to help ensure a camper's health and safety while participating in the camp, retreat, or activity for which you are registering. The information is confidential and will be held in strict confidence. It will be shared only with qualified first aid or medical personnel if required. It will be retained for up to twelve (12) months and then destroyed. If you have questions about the collection or use of this information, please contact the CWM Privacy Officer, Debra Donohue at 1-877-411-2632, ext. 4, or debra@communityofchrist.ca.

Name of camper:	Date of Birth:	
Emergency contact (name and phone):	Health Card No.	Issuing Province:

**Note: If you are travelling out-of-province, additional health insurance may be required.*

Family Physician (name and phone):

Allergies - food, medicine, environmental (if none, so state):

Please describe allergic reaction (ie. rash, anaphylaxis):

Has the camper been immunized? Yes No Are immunizations current? Yes No

Provide details, if any:

Camp Activity Restrictions: None Strenuous activities Swimming Other (describe)

MEDICATIONS

parent initial	I give permission for camp medical staff to administer over the counter medications as required to treat minor illness and injury (ie. Tylenol, Advil, Benadryl, Gravol, lozenges)
parent initial	I give permission for camp medical staff to administer emergency response medications such as antihistamines and epinephrine as required.

Does camper carry **non-prescription** medications? No Yes - Please list medication(s) and purpose(s) below.

Name of Medication	Dosage	Frequency	Reason for Taking

Does camper carry **prescription** medications? No Yes – Please list dosage and instructions below.

Name of Medication	Dosage	Frequency	Reason for Taking

MEDICAL CONDITIONS/HISTORY

Please check if any of the following conditions apply to the camper and provide relevant information:

<input type="checkbox"/> ADD / ADHD	<input type="checkbox"/> Blood born illness or communicable disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Headaches
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Cramps	<input type="checkbox"/> Fainting	<input type="checkbox"/> Homesickness
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Gastrointestinal Disorders <i>(ie. Crohns, Colitis, IBS, Chronic Constipation or Diarrhea)</i>	<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Diabetes		<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Other:			

Please provide additional details:

- Special needs or consideration related to developmental delays or physical disabilities
- Recent emotional upset (death of loved one, divorce of parents, etc.), please describe:
- Other (please describe):

MENTAL HEALTH POLICY

Mental health concerns include any significant events over the last six months which may include hospitalization, suicide attempts, self-harm or psychiatric care. At youth events, staff take any threats or acts of suicide or self-harm very seriously. If these become an issue for your child, parents/guardians will be contacted by camp staff and, if necessary, your child will be taken to the nearest, appropriate medical facility.

- Yes - Briefly describe any mental health concerns. Camp medical staff will personally discuss these concerns with you.

- No, we do not have any mental health concerns

PERMISSION FOR MEDICAL TREATMENT:

The undersigned, hereby authorize any necessary medical treatment for myself or the above-named (if parent/guardian). I also guarantee payment of all charges incurred during this medical treatment (physician, hospital, x-ray, lab, medicines, ambulance, other).

_____ Date: _____
Typed name of camper or Parent/Guardian if camper is under the age of 18.

OTHER INFORMATION/COMMENTS: