**Medical Information** This medical information is required to help ensure your 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 Canada West Mission Centre Privacy Officer, Debra Donohue at 1-877-411-2632, ext. 4, or debra@communityofchrist.ca.

| Name: | *Health Card No. |
|---|---|
| *Note: If you are travelling out-of-province, additional health insurance may be required.* | |
| Family Physician: | Phone |

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

Special Dietary Restrictions (if none, so state):

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

Is camper currently under a physician's care for any acute or chronic condition? ☐ Yes ☐ No If yes, please explain:

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

Does camper carry **prescription** medications? ☐ No ☐ Yes – Please list dosage instructions and any other helpful information on a separate piece of paper.

Are there any medications which should not be given (ie. Tylenol, throat lozenge, laxative, etc.):

**Does camper have any history of, or is he/she being treated for the following:**

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ Anemia | ☐ Appendicitis | ☐ Arthritis | ☐ Asthma | ☐ Athlete's Foot | ☐ Bronchitis | ☐ Diabetes |
| ☐ Digestive disorder | ☐ Epilepsy seizures | ☐ Fainting | ☐ Fractures | ☐ Headaches | ☐ Heart condition | ☐ Hepatitis |
| ☐ High blood pressure | ☐ HIV | ☐ Hypoglycemia | ☐ Kidney trouble | ☐ Low blood pressure | ☐ Nervous System disorder | ☐ Hernia |
| ☐ Skin disease | ☐ Skin ulcer | ☐ Sore throats | ☐ Tonsillitis | | | ☐ Other |

If yes to any of the above, please explain:

**Please check if any of the following conditions apply to the camper:**

| | | | | |
|---|---|---|---|---|
| ☐ Cramps | ☐ Bed Wetting | ☐ Stomach aches | ☐ Homesickness | ☐ Hearing problems |
| ☐ Diarrhea | ☐ Constipation | ☐ Frequent colds | ☐ Fainting | ☐ Vision problems |
| ☐ Toothaches | ☐ Ear aches | ☐ Headaches | ☐ Sleepwalking | ☐ Recent emotional upset (death of loved one, divorce of parents, etc.), please explain: |
| ☐ Nosebleeds | | | ☐ Swimmer's Ear | |

## 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:_____

***Signature** of camper or Parent/Guardian if camper is underthe age of 18.*