



Staff Health Form



Please complete the enclosed form as stipulated in the Staff Contract and return to the Camp Director by **June 1** (P.O. Box 23108, Ottawa, Ontario, K2A 4E2). All parts of this health form must be completed **in full** (by the parent/guardian IF the staff member is under the age of 18). The form DOES NOT have to be filled out by a physician. This form will remain in the Health Centre (infirmary) for the duration of the summer.

STAFF SURNAME											
GIVEN NAME											
DATE of BIRTH				AGE				SEX			
month			date			year					

MAIN CONTACT: Home address of parent(s) or guardian (if under 18)

FAMILY NAME												<input type="checkbox"/> MR.&MRS.		<input type="checkbox"/> MR.		<input type="checkbox"/> MRS.		<input type="checkbox"/> OTHER	
FIRST NAME(S)												HOME TELEPHONE							
ADDRESS												FATHER'S BUSINESS PHONE							
CITY												MOTHER'S BUSINESS PHONE							
PROVINCE/STATE												CELL PHONE							
POSTAL/ZIP CODE												RELATIONSHIP TO STAFF							

EMERGENCY CONTACT

NAME												RELATIONSHIP TO STAFF							
HOME TEL.												CELL PHONE.							

MEDICAL INFORMATION (LEGIBLE PHOTOCOPIES OF THE HEALTH CARE CARDS MUST BE PROVIDED INCLUDING ANY HEALTH INSURANCE CARDS FOR POSSIBLE PRESCRIPTION DRUGS).

OHIP NUMBER												EXPIRY DATE		Y Y Y Y - M M - D D					
QUEBEC MEDICARE NUMBER												EXPIRY DATE		Y Y Y Y - M M					
OTHER PROVINCE/STATE/COUNTRY/INSURANCE PLAN (NAME & NUMBER)																			

If unable to reach your parent / guardian (and under 18 years of age) or the emergency contact given on this form, the Camp Director (s) are hereby authorized to act in accordance with their judgment in the prevailing circumstances.

Signature of parent or guardian (if under 18) or your signature (if over 18) _____

Date _____

MEDICAL INFORMATION - Questions to be completed by either yourself, a physician OR parent/guardian (IF REQUIRED, PLEASE ATTACH ANOTHER PAPER IN ORDER TO PROVIDE COMPLETE EXPLANATIONS).

1. Are there any problems, medical or otherwise that the doctor / nurse should know about?

2. Please list and explain any restrictions, in terms of activities, that you might have at camp.

3. MEDICATIONS BEING TAKEN

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications.

If medication is taken during the school year but NOT during the summer, an explanation is required:

ANY MEDICATION BROUGHT TO CAMP MUST BE IN ITS ORIGINAL CONTAINER WITH THE PERSON'S NAME ON IT AND BE BROUGHT TO THE HEALTH CENTRE (infirmary). For your safety and the safety of others, NO MEDICATION WILL BE ALLOWED TO BE KEPT IN THE BUNK.

4. Apart from your family doctor, are you being followed by any other physician (including psychiatrists), psychologist or mental health care worker? If yes, please specify and provide names and contact information.

5. Do you have any dietary restrictions (e.g. vegetarian, lactose intolerant, gluten free)? _____

6. **ALLERGIES** List all known Describe reaction and management of reaction

Medication allergies (list)

Food allergies (list)

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

7. Are your vaccinations up-to-date? MMR Chicken Pox **Date of last tetanus booster:** _____

8. Have you ever had chicken pox? Yes No

9. Please provide any medical or surgical history, with approximate dates:

Family Physician's / Pediatrician's Name: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Telephone No.: _____

The person referred to above is physically able to attend camp and is free from all communicable or infectious diseases and is able to engage in all activities except as noted on the health form.

Signature (parent or guardian if under 18) OR YOUR SIGNATURE _____

Date: _____