CAMP ARTABAN 2018 CHILD HEALTH RECORD

ALL INFORMATION IS KEPT CONFIDENTIAL. PLEASE ANSWER ALL OF THE QUESTIONS.

Name: ________________________________ **Session Name/Date:** ___________________________

Parent/Guardian's Name: __________________ **Parent/Guardian's Name:** ______________________

Please provide as many different phone numbers as possible, so that you can be contacted in the event of an emergency.

Phone: (H) ____________________ **(W)** __________________ **(C)** ____________________________

Email: _________________________

Date of Birth: YYYY _________ **MM** _____ **DD** ______ **Height:** _________ **Weight:** ________

Family Doctor: ______________________________ **Doctor's Phone:** _________________________

Date of last Tetanus shot: _______________ **Care Card #** __________________________________

1. IS YOUR CHILD SUBJECT TO / DOES YOUR CHILD WEAR (check all that apply):

- ☐ EAR INFECTIONS (L) or (R)
- ☐ MOTION SICKNESS
- ☐ HEADACHES
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ NIGHTMARES
- ☐ SLEEPWALKING
- ☐ BEDWETTING
- ☐ SEIZURES
- ☐ CONTACT LENSES/GLASSES
- ☐ HEARING AID
- ☐ OTHER PROSTHESIS ______________________

2. DOES YOUR CHILD HAVE ALLERGIES? (attach additional information if needed)

Medication: _____________________ Reaction: ______________________________________

Food: _________________________ Reaction: _____________________________ EpiPen? _________

Other (i.e. bees) __________________ Reaction: _____________________________ EpiPen? _________

3. DOES YOUR CHILD HAVE A PROLONGED HEALTH CONDITION? (diabetes, epilepsy, deafness, asthma, etc., or any physical limitations) ARE ANY ACTIVITIES TO BE RESTRICTED? PLEASE DESCRIBE FULLY: ______________________________

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4. **MEDICATIONS:** PLEASE BE SURE TO BRING ALL NECESSARY PRESCRIPTIONS TO CAMP. OUR HOSPITAL IS STOCKED WITH BASIC MEDICINES AND FIRST AID SUPPLIES ONLY. **IMPORTANT: PLEASE SEND ALL MEDICATION IN ORIGINAL CONTAINER WITH PATIENT NAME, NAME OF MEDICATION, DOSAGE AND DOCTOR. ALL MEDICATION WILL BE COLLECTED BY THE NURSE ONCE THE CAMPERS ARRIVE AT CAMP.**

MEDICATION: ____

5. DOES YOUR CHILD HAVE ANY SPECIAL DIFFICULTIES? AT SCHOOL, DOES HE/SHE REQUIRE EXTRA ASSISTANCE? IF SO, PLEASE DESCRIBE: ____

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6. ARE THERE ANY SPECIAL CONCERNS RELATED TO YOUR CHILD'S BEHAVIOUR THAT STAFF NEED TO BE AWARE OF? YES ☐ NO ☐ IF SO, DESCRIBE ANY MANAGEMENT PLAN THAT YOU HAVE FOUND TO BE EFFECTIVE WITH YOUR CHILD:

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7. HAS YOUR CHILD HAD MEDICATION FOR ADHD OR ADD? YES ☐ NO ☐

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8. DOES YOUR CHILD HAVE ANY DIETARY RESTRICTIONS? YES ☐ NO ☐
PLEASE LIST: (meat, dairy, eggs, etc.) ____

NOTE-CAMPERS FROM HOMES WHERE THERE HAS BEEN RECENT DIARRHEA, OR WHO HAVE HAD DIARRHEA DURING THE THREE WEEKS BEFORE THEIR CAMP, CANNOT BE ACCEPTED WITHOUT A LETTER FROM THE FAMILY PHYSICIAN.

IF YOU HAVE ANY SPECIAL NEEDS OR CONCERNS YOU WOULD LIKE THE NURSE TO BE AWARE OF, PLEASE E-MAIL OUR HEALTH/SAFETY NURSE DIRECTLY AT health@campartaban.com ANY TIME. YOU CAN ALSO CONTACT THE CAMP OFFICE AT 604-980-0391. ADDITIONAL INFORMATION MAY BE SUBMITTED ON A SEPARATE SHEET.

RELEASE OF LIABILITY:

I certify that the information provided is correct and that the applicant is physically, mentally and emotionally fit to attend camp. I give permission for photographs of the camper to be used in future camp promotional material. I recognize that there is some element of risk in any adventure, sport or activity associated with outdoor activities in a wilderness area such as Camp Artaban. I understand and agree that in case of accident, sickness or undisclosed condition or inappropriate behaviour of my child during camp, parents/guardians are responsible for any expenses incurred. (It can cost up to $190 for water taxi to Horseshoe Bay.) I give permission for the camp nurse or health worker to take any measures deemed necessary to maintain my child's health while at Camp Artaban, including any necessary emergency measures should they be unable to contact my family doctor or me at the time of an emergency. I release the Diocese of New Westminster, the Board of Directors of the Camp Artaban Society and their respective officers, employees, volunteers and agents from liability for claims for injuries or property loss arising from my child's attendance and participation in activities at Camp Artaban. I further agree to indemnify the said Board of Directors and hold them harmless from any such claims.

PARENT OR GUARDIAN SIGNATURE: ______________________ PRINT NAME: ___________________________