

CAMP TEKAKWITHA

HEALTH CERTIFICATE

To be filled by the parents

DATE OF STAY:.....
CHILD'S NAME..... AGE.....DATE OF BIRTH.....

Address.....

City.....Zip code.....Telephone.....

Health Insurance Company:.....

Policy number:.....Certificate:#.....

Policy Holder..... Emergency line.....

Name of the person responsible for the child.....

Second address where we can reach you during camp:

.....

In case of absence, name of the persons we can reach

Name..... Telephone.....

Name..... Telephone.....

Did your child had:

chickenpox, measles, whooping cough, mumps, German measles.

Does he suffer from?

asthma, sleepwalking, allergy, otitis, enuresis, epilepsy, hearth problem, neurological problems, intestinal problems.

Please give us more details about your child's health problem (if any).....

.....

.....

Does he have any allergy to medications?..... Yes No

If yes, please specify.....

.....

.....

Does he take any medications? Yes No
If yes specify name of medication and posology

.....
Date of last tetanus shot (DPT or DT).....
If this last shot is more than 10 years old, the teenager must have a new one.

Date of the last Polio recall, (sabin or salk).....

Date of the last MMR shot.....

Does your child have his own EpiPen or Ana-Kit for his allergies?

Yes No

If yes, who is the person authorized to administer and keep this medication

the child himself. Posology: _____

the counsellor

any responsible adult

To be signed if your child has his EpiPen or Ana-Kit at camp.

I, undersigned, authorize any responsible person designed by the authority of Camp Tekakwitha to administer in case of emergency his dose of adrenaline _____ to my child

Signature

Girls:

Did she already have her first periods: Yes No

Are there any particular precautions to take?.....

.....

In case of emergency, I authorize the direction of Camp Tekakwitha to take good care of my child's health by a competent personal member, and give him or her all necessary care to my child (This section must be filled

Signature.....

Date.....

N.B. The medical examination is not required unless your child suffer from a particular health problems: Ex: chronic diseases or any recent heath problem(pneumonia, impetigo, other infections) If so, thirty days before camp, please have your child examined by a physician for a medical check-up.

To be filled by the physician

Child's name.....

This child has been examined. His physical health is stated satisfactory and he can participate to all the activities

Important: please state any precautions to take:

.....
.....
.....
.....
.....
.....
.....
.....
.....

Physician's name.....

Signature.....

Address.....

Telephone.....

Participant's Health Record

AUTHORIZATION TO ADMINISTER NON-PRESCRIPTION MEDICATION

NAME OF CAMPER: _____

If need be, I authorize camp personnel to administer one or more of the medications listed below:

- Acetaminophen (Tylenol, Temptra, etc.)
- Anti-emetic product (Gravol)
- Antihistamine against allergies (Benadryl, Claritin, Allegra, Reactine, Phenergan, etc.)
- Cough syrup (Benylin, etc.)
- Acetylsalicylic acid (Aspirin)
- Anti-inflammatory medication (Advil)
- Antibiotic cream (Polysporin, Neosporin, Baciguent, etc.)
- Other: (medication accompanying the child, provided by the parents)

This list contains products most likely to be administered to campers by staff in charge of camp hygiene and health. Parents or guardians of children must check each item authorized separately. Moreover, it is better to indicate the type of medication rather than brand names such as Tylenol, Aspirin or Gravol (i.e. acetaminophen rather than Tylenol). This authorization also applies to all homeopathic remedies.

In case of emergency, I authorize the direction of Camp Tekakwitha to take good care of my child's health by a competent staff member and give him all necessary care. If needed, I authorize the Camp to use any good transportation to go to the nearest hospital. I authorize the physician chosen by the authorities of Camp Tekakwitha to give him all medical care required. If I cannot be contacted, I authorize all necessary medical treatments, surgical intervention, anaesthesia and hospitalization.

Signature.....

Name of the camper.....

Signature: _____

Date _____