CAMPER/STAFF HEALTH HISTORY

TO BE FILLED IN BY PARENT OR GUARDIAN

MUST ACCOMPANY CAMP APPLICATION

Please note: These forms are Confidential and only available to the Nurse and Director

Please tick camp that your child/staff is attending:

☐	Girls Camp (Ages 8–13)	July 8 – 12, 2019
☐	Junior Coed Camp (Ages 8-13)	July 15 - 19, 2019

This form is intended as a guide to the Camp Staff. Full answers to the questions are very important and would be appreciated.

NAME OF CAMPER/STAFF_____

Age: _____ M.C.P. NUMBER_____

Home Address _____

PERSON TO NOTIFY IN CASE OF EMERGENCY_____

ADDRESS_____ PHONE**(H)**_____**(W)**_____

Is camper/staff subject to:

HEADACHES_____ FREQUENT COLDS ____ SORE THROAT OR TONSILLITIS____
BRONCHITIS _____ASTHMA_____ HAY FEVER _____ FAINTING _____
HYSTERIA ____ SLEEPWALKING _____ BEDWETTING _____ NOSEBLEEDS _____
OTHER (PLEASE SPECIFY)_____

(FOR GIRLS ONLY) Has she started her menstrual periods?_____
If not, does she know about the process?_____

Any **important medical concerns** the camp nurse should be aware of? (eg. ADD, Diabetes)
_____
_____

HAS CAMPER/STAFF HAD ANY **SERIOUS ILLNESS**, OR **HOSPITALIZATION**_____
If so, give particulars and dates_____
_____
_____

Is there any reason why she/he should not go swimming?_____

PLEASE TURN OVER >>>>>>>>>>>>>>

IMMUNIZATIONS:

Has s/he had been immunized against:

*If **less than 13 years** of age, please **answer Part A only**:*

Part A.
Measles_____ Mumps_____ Rubella____ Diphtheria_____ Polio____Tetanus_____
Pertussis_____ HIB_____

*If **more than 13 years** of age, please **answer Part B also**:*

Part B.
Booster_____ Diphtheria_____ Polio_____ Tetanus_____

Other Medical Information

Is there any physical disorder that would prevent him/her from taking part in camp activities?_____

Does camper/staff have any allergies?_____

IF YES, TO WHAT?_____
_____

Will the camper/staff be taking any medication while at camp? Yes___ No___ . If **yes**, please note that medication, with instructions, must be turned in to the Camp Nurse at registration.

List names of any long-term medications_____
_____
_____

NAME OF FAMILY DOCTOR_____PHONE_____

ADDRESS OF FAMILY DOCTOR _____

Has your child had suffered from any physical or psychological trauma that may cause upset for your child (ie. recent death, divorce, family illness, etc.)? Yes___ No___
If yes please list for the benefit of the Nurse and Director. **This will remain strictly confidential to the Nurse and Director. If you would prefer you can call and speak with the Camp Director personally.**

SIGNATURE OF PARENT/GUARDIAN/STAFF_____

RETURN **IMMEDIATELY** TO: Lavrock Camp Committee
19 King's Bridge Road
St. John's, Newfoundland A1C 3K4

PLEASE MAKE SURE OTHER SIDE COMPLETED >>>>>>>>>>>>>>>>