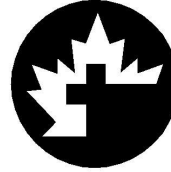


**In This Space
Please Attach a
Copy of the
Camper's Health
Card**



Camp Crossroads
1224 East Bay Rd.
Torrance, POC 1M0
705-762-3111

Camp Week _____

Dates _____

Camp Crossroads - Campers' Health Information.

Campers must bring this form to Camp and give to the camp nurse.

Camper's Name:

Age:

Wt/lbs:

Birth Date:

Address:

City:

Postal Code

Home Phone:

Parent/Guardian Name & Address at time of Camp Week

Home Phone: ()

Work Phone: ()

Emergency Contact:

Relationship

Home Phone:

Family Doctor's Name & City:

Phone #:

Past Health History - Pertinent to the care of your child. (Illness, Operations, Diseases, Bed wetting, poor appetite etc.) Attach separate sheet if necessary.

Present Health Conditions (include fears, anxieties, recent losses):

Allergies	Type of Reaction	Treatment
Medications		
Food		
Other – horses, environment Bee stings etc.		

If your child uses an epi-pen, do they know how to administer it themselves?

Yes

No

When was the last time your child required this medication?

Please turn over



Medications your child is bringing to camp and time that it is to be given:	
Medication	Times

Medications must be in their original containers, labeled with name and instructions. If more space is needed, use separate sheet.

Has your daughter been told about menstruation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has your daughter menstruated?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

The following medications are provided at camp. Please initial which medication your child may be given by the camp nurse if required.

- | | | | |
|-------------------------------|--------------------------|----------------------------|--------------------------|
| Gravol (nausea/vomiting) | <input type="checkbox"/> | Robitussin (cough) | <input type="checkbox"/> |
| Tylenol (fever/pain) | <input type="checkbox"/> | Benylin DM (cough) | <input type="checkbox"/> |
| Ibuprofen (anti-inflammatory) | <input type="checkbox"/> | Sudafed (decongestant) | <input type="checkbox"/> |
| Pepto-Bismal (antacid) | <input type="checkbox"/> | Magnolax (laxative) | <input type="checkbox"/> |
| Benadryl (anti-histamine) | <input type="checkbox"/> | Kaopectate (anti-diarrhea) | <input type="checkbox"/> |
| (pill/cream) | <input type="checkbox"/> | A535 (sore muscle rub) | <input type="checkbox"/> |

Immunization: (Tetanus, Polio, Diphtheria, MMR) Date of last DPT & P immunization: _____ Comments:
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Special (non-medical) food restrictions or requirements (i.e. due to religious beliefs)

My child is in good health and has not been exposed to any infectious diseases **in the past month**. If there is a surgical emergency and we are not immediately available for consultation, I hereby grant permission for the director of Camp Crossroads (or designate) to obtain, with a physician consult, the proper treatment, hospitalization, injections, anesthesia or surgery to the above named child.

I understand that the information recorded here is necessary for my child's safety and well being at Camp and that this information will be treated in a respectful and caring manner.

Date: _____

Signature of Parent/Guardian: _____