PEI 4-H CAMP PROGRAM - HEALTH INFORMATION FORM

This form is to be signed and completed by a parent or guardian and returned with the Participant's Conduct Form, Camp Application and registration fee. Accurate and complete information is essential. These forms are confidential and will be available only to 4-H staff and a physician, if necessary. The parent or guardian is assuming full responsibility for the participant's health being such that the program activities will in no way aggravate any condition present. This program may be of a strenuous nature both physically and mentally.

Name of Participant _____
(surname) (first) (middle)
Mailing Address _____ **Postal Code** _____

Primary Phone _____ **Date of Birth** _____

Health Card Number (Not S.I.N.) _____**Expiry Date**_____

Other Hospital Insurance_____

In Case of Emergency Notify _____

Relationship to Camper: _____

Address _____

Home Phone _____ **Cell Ph:** _____

Doctor's Name _____ **Phone** _____

PERSONAL HEALTH RECORD

Check any of the following conditions which the participant is subject to:

__ Asthma
__ Tonsillitis
__ Sinus Trouble
__ Bronchitis
__ Convulsions
__ Skin Condition (contagious)
__ Epilepsy
__ Eye Trouble
__ Boils
__ Frequent Colds
__ Ear Trouble
__ Skin Condition (non-contagious)
__ Kidney Trouble
__ Motion Sickness
__ Fainting
__ Rheumatism
__ Hysteria
__ Nightmares
__ Sleep Walking

Please give details of usual treatment should indicated condition occur:

_____

Other medical concerns (e.g. Diabetes) of which the program staff should be made aware? (Specify - give details of medication necessary.)

_____
_____

Check any of the following allergies which the participant is subject to:

__ animals	__ drugs	__ dusts	__ foods
__ plants	__ pollens	__ insect stings	__ other

Specify: _____
Signs/Symptoms: _____
Treatment: _____

Check any of the following illnesses which the participant has had:

__ Appendicitis	__ Jaundice	__ Pleurisy	__ Scarlet Fever
__ Chicken Pox	__ Measles	__ Pneumonia	__ Tuberculosis
__ German Measles	__ Mumps	__ Pneumatic Fever	__ Whooping Cough

Any illness or disability not included on this list: _____

Recent operations and injuries (give dates and nature): _____

Precautions that have been advised: _____

Date of last tetanus immunization: _____

The program may include rigorous activities. Does the applicant suffer from any physical or emotional disorders that would prevent full participation in this program? Yes __ No __
(if yes, state particulars) _____

Is the participant currently taking medication? Yes __ No __
Name of Drug: _____ Dosage: _____
Condition for which drug was prescribed: _____

As the parent/guardian of the participant, under circumstances as stated below, I hereby authorize the leader in charge of the program to secure such medical advice and treatment as may be deemed necessary for the health and safety of my child or ward _____, and I agree to accept financial responsibility in excess of the benefits allowed by the Provincial Health Plan:

1. Where the health and well-being of the participant is involved.
2. Where medical advise has been such that further services are required - services which require the consent of parent/guardian.
3. Where all attempts to contact the parent/guardian have failed, or where due to the nature of the emergency there is insufficient time to contact such parent/guardian, it will be at the discretion of the leader in charge of the program to decide what steps must be taken for the welfare and safety of the delegate.

_____ _____

(*Date)* ***(Signature of Parent/Guardian)***