

Do Not Fax - This form must be mailed in with your contract
This Form Must Be Returned to Ensure Proper Care in Case of Injury or Illness.

WALDEN - Staff Health History

Staff's Name: Last _____ First _____ Sex: Male Female Height ___" Weight ___ lbs
Names of Parents (Dr./Mr.) _____ (Dr./Mrs./Ms.) _____
Home Address: _____ City _____ Province/State _____
Postal/Zip Code: _____ Date of Birth: Month _____ Day _____ Year _____
Father Home Phone #: Area _____ Number _____ Mother Home Phone #: Area _____ Number _____
Father Business Phone #: Area _____ Number _____ Mother Business Phone #: Area _____ Number _____
Father Cell Phone #: Area _____ Number _____ Mother Cell Phone #: Area _____ Number _____
Father Other Phone #: Area _____ Number _____ Mother Other Phone #: Area _____ Number _____
Emergency Contact - In case of illness/emergencies (when parents are unable to be reached) please notify: _____
Relation: _____ Home Phone #: Area _____ Number _____ Cell Phone #: Area _____ Number _____

Canadian Staff, please provide your provincial health card number (or a photocopy of the card) and ensure information is complete and accurate.
Province: _____ Health Card #: _____, Version Code: _____
Out of Canada Staff - please list any medical plans and numbers. Plan and #: _____

Immunization Record - Date of last injection:

- Diphtheria/Tetanus/Polio/Pertussis _____ Adacel _____
 HIB _____ Measles/Mumps/Rubella _____
 Chicken Pox _____ Hep B _____ Prevnar _____
 Menjugate/Menomune _____
 TB Test _____ TB Test Result _____

Allergies:

- *EpiPen Needed Bee Sting Insect Bites *Animals
 *Foods *Drugs Penicillin *Others

*Please specify which: _____

IT IS IMPERATIVE YOU PROVIDE THE HEALTH CENTER STAFF WITH INFORMATION ON ALL OF YOUR HEALTH AND MEDICAL ISSUES. THIS INFORMATION ALLOWS THE HEALTH STAFF TO PROVIDE YOU WITH THE SAFEST AND BEST CARE DURING THE SUMMER AND IN THE EVENT OF AN EMERGENCY SITUATION.

Do you have any special requests, needs or directions that you wish the camp health staff to note? (physical limitations, learning disabilities, dietary restrictions, etc.) _____

Are there any medications or injections you will be taking during the summer? Yes No If so, please state clearly when and how often these are to be administered.

Medication Name	Dosage	Administration Times
1. _____		
2. _____		
3. _____		

All medications must be clearly labelled in their original container with written instructions and given to the health center upon your arrival at camp.

Are there any items of a medical nature that we should be aware of?
Please specify: _____

Are there any medications you have chosen to discontinue while at camp during the summer? Yes No If yes, please specify name of medication: _____

Have you or are you receiving psychological, group counselling or psychiatric care or assistance? If yes, please explain (attach a letter if necessary) _____

Family Doctor's Name _____ **Phone #:** () _____

Do you currently have or experience any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> headaches | <input type="checkbox"/> sinus trouble |
| <input type="checkbox"/> ear infections | <input type="checkbox"/> heart condition | <input type="checkbox"/> sleepwalking |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> hepatitis | <input type="checkbox"/> urinary tract infection |
| <input type="checkbox"/> diet restrictions | <input type="checkbox"/> hernia repair | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> earplugs/tubes | <input type="checkbox"/> menstruation | |
| <input type="checkbox"/> eyeglasses | <input type="checkbox"/> seizures | |
| <input type="checkbox"/> hay fever | <input type="checkbox"/> stomach aches | |

Dates of Communicable Disease

Dates	Dates
<input type="checkbox"/> chicken pox _____	<input type="checkbox"/> hepatitis _____
<input type="checkbox"/> measles _____	<input type="checkbox"/> mumps _____
<input type="checkbox"/> scarlet fever _____	<input type="checkbox"/> tuberculosis _____
<input type="checkbox"/> whooping cough _____	<input type="checkbox"/> other _____

To the best of my knowledge, I am in good health and have not been exposed to any infectious diseases in the past four weeks. **If I become exposed to any infectious diseases, or any change in health status, between now and the beginning of the camp period, I understand the camp must be notified in writing.** In case of emergency, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for and to order injections, anaesthesia or surgery for me. I am aware that my pertinent medical information may be shared with the appropriate health or senior staff.

I have disclosed all pertinent medical information including information regarding prescription medications. I hereby give permission to allow my physician to give Camp Walden medical information about myself should it be required by the camp.

_____ Date

_____ Signature of Staff Member

(if under 18 years, have parent sign)

