

CAMP HATIKVAH MEDICAL FORM Page 1	BOTH PARENTS AND PHYSICIAN TO SIGN	SUBMIT BY MAY 1, 2012
Camper Name: _____	Session: _____	Birth Date: _____
Medical Number: _____	Dental Plan Name & Number: _____	
Parent Names & Numbers: Name: _____ Home Tel: _____ Cel: _____ Bus Tel: _____		
Name: _____ Home Tel: _____ Cel: _____ Bus Tel: _____		
Indicate what, if any, medical condition/diagnosis is present: _____		
General Symptoms: In addition to above, does this participant have any problems with the following:		
<input type="checkbox"/> Headaches <input type="checkbox"/> Migraine <input type="checkbox"/> Hayfever/seasonal allergies <input type="checkbox"/> Fainting/dizziness <input type="checkbox"/> Asthma <input type="checkbox"/> Skin condition <input type="checkbox"/> ENT problem <input type="checkbox"/> Musculoskeletal problems <input type="checkbox"/> Recurrent tonsillitis <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Recurrent abdominal pain <input type="checkbox"/> Other: _____		
Details: _____		
Does this participant suffer from anxiety, depression, homesickness, body image issues or learning/attentional problems?		
<input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, explain): _____		
Does this participant have any other psychiatric and/or behavioural conditions that currently require or have required treatment?		
<input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, explain): _____		
Do you have any concerns about this participant's habits, physical or emotional needs?		
<input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, explain): _____		
Has there been any significant change in this participant's family or household composition? Has there been significant stress or trauma?		
<input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, explain): _____		
<p style="text-align: center;">Immunizations:</p> Date of last tetanus shot: _____ Has your child had MMR? _____ Has your child had chickenpox illness or shot? _____ Has your child had Menjugate vaccine ¹ ? _____ Has your child had Hepatitis B vaccine ² ? _____ Has your child had Hepatitis A Vaccine ³ ? _____ Were any early immunizations missed? _____	<p style="text-align: center;">Sleep habits:</p> <input type="checkbox"/> enuresis (attach details) <input type="checkbox"/> sleepwalking/nightmares (attach details)	
<p style="text-align: center;">Diet:</p> <input type="checkbox"/> no diet concerns <input type="checkbox"/> vegetarian <input type="checkbox"/> extremely picky eater <input type="checkbox"/> lactose intolerant <input type="checkbox"/> other special diet: _____		

¹ Currently recommend, but parents need to purchase

² 2 or 3 shots usually given at school

³ Not currently on routine vaccination schedule, but some children have received this

Medical Consent (to be completed by both legal guardians) Page 2

To the best of my knowledge, the health history provided is true and correct. My child can participate in all activities as noted in this form. If we cannot be reached in an emergency, we give permission to the physician selected by the Camp Director to hospitalize secure treatment for and order injection, anesthesia and surgery for our child. If our child has been exposed to a serious communicable disease between the undersigned date and his/her departure for camp, we will immediately inform the camp.

I/We agree that the relationship between our child and the Medical Doctor providing treatment at Camp Hatikvah and medical staff of Camp Hatikvah shall be governed by and construed in accordance with the laws of the province of British Columbia, Canada.

I/We acknowledge that any treatment/services was performed in the Province of British Columbia and that the Courts of the Province of British Columbia shall have jurisdiction to entertain any complaint, demand, claim or causes of action, whether based on alleged breach of contract or alleged negligence arising out of treatment. I/We hereby agree that we will commence any such legal proceedings only in the Province of British Columbia, Canada and hereby submits to the jurisdiction of the Courts of the Province of British Columbia, Canada.

Mother's Name: _____ Signature: _____ Date: _____

Father's Name: _____ Signature: _____ Date: _____

The following section to be completed by a physician

Patient's Weight: _____	Patient's Height: _____	Have you reviewed and verified the information compiled by this patient's parent or guardian? <input type="checkbox"/> Yes
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Serious Allergic Reactions:

- Bee/Wasp Stings: _____
- Nuts: _____
- Other foods: _____
- To medication: _____
- Other: _____

Type of Reaction (symptoms): _____

 Treatment: _____

Any camper carrying an epipen should have their status reviewed by an allergist

Medical Conditions/Diagnosis:

Indicate what, if any, medical condition/diagnosis is present: _____

Indicate any relevant past medical history or surgery: _____

Regular Medications:

- This patient requires regular medication and s/he will bring them to camp
 List name, dosage and frequency: _____
 List name, dosage and frequency: _____
- This patient requires PRN medications and s/he will bring them to camp
 List name, dosage and frequency: _____
 List name, dosage and frequency: _____

Physical Examination:

- Normal examination
- Positive physical findings: _____

Examiner's Name: _____ Are you the patient's regular physician? No Yes

Signature: _____ Date: _____ Stamp: _____

Phone: _____ Fax : _____ E-Mail: _____