

Mail To: Harbourfront Centre Camps
235 Queens Quay W.
Toronto, ON M5J 2G8

Fax To: Camp Office
416-973-5377

The information on medical records is considered to be private and available only to the Health Care Director and relevant Camp staff. This information is meant to assist us in providing the best possible care for all campers in our programme. Please provide us with as much detail as possible and be specific when answering all of the questions. **Errors on this form may result in delays in caring for your child.** Medical information is not retained form year to year. **Please complete BOTH PAGES of this form and RETURN IMMEDIATELY by mail or fax.**

CAMPER INFO

Child's Last Name: _____ Child's First Name: _____

Camp Name(s) and Session(s): _____

Home Phone Number: _____ Date of Birth (D/M/Y): ___ / ___ / ___ Sex: Male Female

Health Card Number: _____ (to be used for emergency purposes only)

Camper's Doctor's Name: _____ Doctor's Phone #: _____

EMERGENCY CONTACT INFORMATION

Primary Contact

Last Name: _____ First Name: _____ Relationship to Child: _____

Home Phone: _____ Business Phone: _____ Mobile Phone: _____

Address: _____ City/Province: _____ Postal Code: _____

Secondary Contact

Last Name: _____ First Name: _____ Relationship to Child: _____

Home Phone: _____ Business Phone: _____ Mobile Phone: _____

Address: _____ City/Province: _____ Postal Code: _____

(If different from primary contact name)

Third Contact

Last Name: _____ First Name: _____ Relationship to Child: _____

Home Phone: _____ Business Phone: _____ Mobile Phone: _____

Address: _____ City/Province: _____ Postal Code: _____

PLEASE COMPLETE BOTH PAGES

Camper's Last Name: _____ Camper's First Name: _____

MEDICAL / BEHAVIOURAL INFORMATION

Immunization: Is your camper's immunization up to date? Yes No If no, please elaborate: _____

Date of most recent booster polio, tetanus, diphtheria: _____

Health/Behavioural Issues: Does your child have any health or behavioural conditions that we should be aware of? For example, diabetes, epilepsy or prone to seizures, heart disease, kidney trouble, auditory or visual impairments, emotional concerns, asthma, special physical needs, home sickness, bed-wetting, death in the family, recent separation/divorce, etc.? Yes No If Yes, please elaborate (attach additional pages if necessary): _____

Allergies: Does your child have any allergies, e.g. food, peanuts, drugs/medication, animals, insect stings, hayfever, etc.? Yes No If Yes, please specify what your child is allergic to, elaborate on the severity of the reaction and best methods of treatment (attach additional page if necessary). _____

Does your camper carry an epi-pen or any other allergy medication? Yes Specify: _____ No

Medication:

1. Does your child require any medication to be taken or administered while at Camp? For example, ANA kit, asthma ventilator, Ritalin, antibiotic, etc. Yes No If Yes, please elaborate: _____
2. Will your child be on a "medication holiday" (i.e. usually takes Ritalin, however is not on it for the summer) while attending camp? Yes No
3. Does your child self-administer the medication or will the Health Care Director be required to do so?
Self-administer Health Care Director

Ongoing Treatment:

Is your child undergoing any form of treatment for any physical or emotional illness, condition or injury? Yes No
If Yes, will this treatment affect or limit participation in camp activities? Yes No

Please elaborate: _____

Dietary Considerations: Does your child have any dietary restrictions or considerations that we should be aware of? Yes No
If yes, please elaborate (NOTE: Substitutions are NOT available for meal plan): _____

Other information: Please elaborate on any other information that may help us in providing the best possible experience for your child (e.g. child's fears, personal goals, past camp history, preferences, etc.) _____

Emergency Authorization: I understand that in registering for camp, that my child(ren) will be partaking in physical activities, and that with any physical activity, there is a risk of injury. In the event of an emergency, I authorize the physician in the emergency care unit selected by Harbourfront staff to secure proper treatment for the child indicated above. I understand that every effort will be made to contact me prior to any treatment deemed necessary. My signature below indicates that the above information is as accurate and complete as possible.

Name (please print): _____ Date: _____ Signature: _____

PLEASE COMPLETE BOTH PAGES