

## Consent

In case of medical emergency, I understand that effort will be made to contact the primary contact or the emergency contact. In the event they cannot be reached, I hereby give permission for the camp director/designate to sign a consent for medical treatment and to authorize any physician or hospital to provide medical assessment, treatment or procedures for the participant named above.

Parent/Guardian Signature \_\_\_\_\_  
Printed Name \_\_\_\_\_  
Date \_\_\_\_\_

### For camp use only

Has the camper been exposed to any contagious diseases within the three weeks prior to their arrival at camp?  Yes  No

Details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Camper Medical Form

Zion Hill Youth Camp

PLEASE PRINT

### Camper Info

Last Name \_\_\_\_\_  Female  
First Name \_\_\_\_\_  Male  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ Prov. \_\_\_\_\_  
Postal Code \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Age as of Sept. 1st, 2018 \_\_\_\_\_  
Health Card # \_\_\_\_\_

### Contact Info

Primary Contact Name \_\_\_\_\_  
Relationship to Camper \_\_\_\_\_  
Home Phone # \_\_\_\_\_  
Work Phone # \_\_\_\_\_  
Cell Phone # \_\_\_\_\_  
**In Case of Emergency Contact:**  
Name \_\_\_\_\_  
Relationship to Camper \_\_\_\_\_  
Home Phone # \_\_\_\_\_  
Work Phone # \_\_\_\_\_  
Cell Phone # \_\_\_\_\_  
Name of Family Physician \_\_\_\_\_  
Doctor's Phone # \_\_\_\_\_

### First Aid Info

I give permission for the medications outlined on the registration form to be administered to my child by the First Aid Attendant of Zion Hill Youth Camp. I consent for First Aid to be administered to my son/daughter as necessary. I also agree that the following medications and lotions/creams may be applied as necessary.

**Please indicate by circling YES or NO.**

YES	NO	Benadryl for allergic reactions
YES	NO	Tylenol for fever or headache
YES	NO	Advil for fever or headache
YES	NO	Gravol for nausea/vomiting
YES	NO	Calamine Lotion (insect bites/minor skin irritations)
YES	NO	Polysporin to prevent infection/speed the healing of minor cuts and scrapes.

Signature of Parent/Guardian: \_\_\_\_\_  
Date: \_\_\_\_\_

## Health History

Any medical, emotional, or behavioural condition(s) not fully disclosed on this health form could result in the camper being sent home from camp. In that event, no refund will be issued.

### Medical Conditions (Please check all that apply)

- None  
 Asthma  
 ADD/ADHD  
 Hearing Problems  
 Behavioural Disorder  
 Seizures  
 Convulsions  
 Diabetes  
 Other Describe: \_\_\_\_\_

### Current Problems

- None  
 Bowel Problems  
 Bedwetting  
 Stomach Aches  
 Homesickness  
 Headaches  
 Sleepwalking  
 Nightmares  
 Frequent Colds  
 Sore Throats  
 Sinus Infections  
 Ear Infections  
 Other Describe: \_\_\_\_\_

### Immunizations

Has your child been immunized?  Yes  No

Type of immunization \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Restrictions in Activities

Yes  No

Describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Allergies

- None  
**Drug Allergies**  
 Penicillin  
 Sulfas  
 Anesthetic  
 Acetaminophen  
 Codeine  
 Other Describe: \_\_\_\_\_  
**Environmental Allergies**  
 Bee Stings  
 Pollen  
 Hayfever  
 Animal Dander  
 Dust/Mold  
 Latex  
 Other Describe: \_\_\_\_\_  
**Food Allergies**  
 Lactose Intolerant  
 Peanuts  
 Nuts  
 Food Dye  
 Gluten  
 Other Describe: \_\_\_\_\_

### DESCRIBE REACTION TO ALLERGIES CHECKED ABOVE:

## Medications

- Name of Medication \_\_\_\_\_  
 Dosage \_\_\_\_\_  
 Frequency \_\_\_\_\_  
 Purpose \_\_\_\_\_
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 Dosage \_\_\_\_\_  
 Frequency \_\_\_\_\_  
 Purpose \_\_\_\_\_

All medications, both prescription and over the counter, must be clearly labelled in an original container, including dosage and instructions for usage from pharmacy and given to the **FIRST AID ATTENDANT** at the time of registration.

### Anaphylactic reaction to allergies Yes No

Epi Pen  Yes  No

Child Knowledge of Use of Epi Pen  Yes  No

Epi Pen kept on child's person  Yes  No

### Ventolin Inhaler Yes No

Child knowledge of use of inhaler  Yes  No

Inhaler kept on child's person  Yes  No

## Important Information

Camp concludes the Saturday of each week at noon. My child will be picked up by \_\_\_\_\_ or by \_\_\_\_\_ (name of 2nd person) \_\_\_\_\_.

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_

**Please Note: Parents/Guardians will now be required to sign their child out at the end of camp.**

### Special Instructions

Please outline any special instructions concerning care, medication, diet, allergies, custody, etc.