HEALTH FORM *for* PLAST CAMPS

Please print, complete, initial and sign this Health Form. To safeguard the privacy of personal information, DO NOT send the completed form by email but, rather, hand it in to camp organizers. Information on this form is not part of the participant or staff acceptance process, but is gathered to assist us in identifying appropriate care.

This form is to be completed by 1. Parents/Guardian(s) for all children and youth (новацтво і юнацтво) attending camp, including those participants who may be over 18 years of age at the time of the camp, 2. Parents/Guardian(s) for volunteers under the age of majority (братчики і сестрички), and 3. All adult volunteers.

I. Identification

Participant's Name (English)
FIRST LAST

Participant's Date of Birth
MM/DD/YYYY

Gender ☐ FEMALE ☐ MALE

Height | Weight | Hair Colour | Eye Colour

Name Of Family Physician | Physician Phone Number
###-###-####

Name Of Dentist/Orthodontist | Dentist Phone Number
###-###-####

First Parent/Guardian: Name
FIRST LAST

Cell Phone
###-###-####

Home Phone
###-###-####

Email

Second Parent/Guardian: Name
FIRST LAST

Cell Phone
###-###-####

Home Phone
###-###-####

Email

Emergency Contact: Name
FIRST LAST

Cell Phone
###-###-####

Home Phone
###-###-####

Relationship

II. Medical/Hospital Insurance

Provincial Health Plan Number

Supplementary Insurance Carrier | Toll Free Phone Number
###-###-####

Insurance Group Number | Insurance Identification Number

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III. Immunizations

If immunized, please include year of immunization. If not immunized but had disease, please include year this occurred.

Tetanus YEAR IMMUNIZED	Diphtheria YEAR IMMUNIZED	Pertussis YEAR IMMUNIZED	Measles YEAR IMMUNIZED	Mumps YEAR IMMUNIZED
Rubella YEAR IMMUNIZED	Polio YEAR IMMUNIZED	Chicken Pox YEAR IMMUNIZED	Hepatitis A YEAR IMMUNIZED	Hepatitis B YEAR IMMUNIZED

IV. Medical History

ADD/ADHD	☐ YES ☐ NO	Anxiety	☐ YES ☐ NO	Asthma	☐ YES ☐ NO
Behavioural Difficulties	☐ YES ☐ NO	Bleeding Disorders	☐ YES ☐ NO	Bone and Joint Problem	☐ YES ☐ NO
Cancer	☐ YES ☐ NO	Colitis	☐ YES ☐ NO	Crohn's	☐ YES ☐ NO
Depression	☐ YES ☐ NO	Diabetes	☐ YES ☐ NO	Eating Disorder	☐ YES ☐ NO
Epilepsy	☐ YES ☐ NO	Headaches	☐ YES ☐ NO	Heart Conditions	☐ YES ☐ NO
Hypertension	☐ YES ☐ NO	IBS	☐ YES ☐ NO	Immune Disorder	☐ YES ☐ NO
Personality Disorder	☐ YES ☐ NO	Recurrent Infections	☐ YES ☐ NO	Other	☐ YES ☐ NO

If you checked 'Yes' for any of the above medical conditions, please explain the condition, as well as the severity and stability of the condition and any necessary information for the camp directorship (булава) below.

Will the participant be taking any medications (prescribed or otherwise) at camp? ☐ YES ☐ NO

If yes, please indicate the medication, dose and timing below:

I allow the participant to be administered commonly available over-the-counter medications on an as needed basis to manage illness and injury by the medical personnel at camp. ☐ YES ☐ NO

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IV. Medical History *continued*

Has the participant been hospitalized or visited an ER in the last 12 months? ☐ YES ☐ NO

If yes, for how long and for what reason?

List any physical, mental or social conditions that may affect or limit full participation in the camp program.

Does the participant have a diagnosis of an allergy from a healthcare practitioner? ☐ YES ☐ NO

What is the participant allergic to?

How many times has the participant had a reaction? _____

Explain past reactions.

Has the participant ever required an EpiPen? ☐ YES ☐ NO

What are the early signs and symptoms of the participant's allergic reaction?

What is the recommended treatment?

Please note that any participant with a known allergy for which an EpiPen has been recommended must have TWO personal EpiPens at camp.

Does the participant have any food allergy or intolerance that requires a special diet? ☐ YES ☐ NO

eg. Lactose intolerance, gluten intolerance/sensitivity. Please note: special diet requests are for food allergies and health-related needs only. Requests should not be for food preferences, personal taste or 'picky eaters'.

If yes, please list allergies or intolerances:

Is the participant vegetarian? ☐ YES ☐ NO

If you wish to discuss any personal health matters of the participant directly with the camp director (комендант) or medically responsible individual at the participant's camp, please check this box and one of the named individuals will contact you prior to the camp.

☐ Please contact me to discuss the participant's health matters

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Is there anything else the camp leadership should be aware of about the participant that will ensure their full participation and enjoyment in the camp?

Parental or Adult Participation Statement

INITIALS To the best of my knowledge, the information in sections I, II, III, and IV, is accurate and complete.

INITIALS I give my permission for full participation in the Summer Camp, subject to limitations noted herein.

INITIALS I give permission for a licensed health care practitioner to examine the participant, to give needed immunization (unless stated otherwise), and to furnish requested information to other agencies as needed.

INITIALS In the event of illness or accident in the course of camp activity, I request that measures be initiated without delay as judgment of medical personnel dictates.

INITIALS If medical information that could compromise the safety of the participant or others at camp is not disclosed, I accept that Plast Canada reserves the right to send the participant home at my expense.

INITIALS The Parent/Guardian or Adult Participant is responsible to notify the camp administrators if there are any changes to the participant's health status or hospitalizations prior to camp.

Plast Canada will make every effort to accommodate all participants, however, we reserve the right to not accept a participant if their needs exceed our capabilities.

Name of Parent, Guardian or Adult Participant

FIRST LAST

Signature of Parent, Guardian or Adult Participant

Date

DD/MM/YYYY