

# Nova Scotia Hemophilia Society - Maritime Adventures Camp Medical Information

(For All Campers)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Date of Birth \_\_\_\_\_

Weight (very important) \_\_\_\_\_ Height \_\_\_\_\_

Health Card Number \_\_\_\_\_

Grade Completed \_\_\_\_\_

Parent#1: \_\_\_\_\_

Address \_\_\_\_\_

Parent #2 \_\_\_\_\_

Address (if different) \_\_\_\_\_

Home Phone# \_\_\_\_\_

Home Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_

Other # \_\_\_\_\_

Other # \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship to child \_\_\_\_\_

Please complete the following medical information for your child, which will be kept confidential. The medical information is to be returned with the other application forms.

General Medical Information: To be completed for all campers by parent or guardian.

Current Medications: Please list current medications and vitamin supplements other than factor products that are required during camp. Please be sure to bring all medications in the original bottle, labelled with the child's name, and directions for administration. All prescription medications must have the original label containing your child's prescription.

Medication	Dosage	Time	Purpose

Allergies:

Drugs Yes\_\_ No\_\_ Describe: \_\_\_\_\_  
Reaction and severity \_\_\_\_\_  
Treatment: \_\_\_\_\_

Food Yes\_\_ No\_\_ Describe: \_\_\_\_\_  
Reaction and severity \_\_\_\_\_  
Treatment: \_\_\_\_\_

Insect bites Yes\_\_ No\_\_ Describe: \_\_\_\_\_  
Reaction and severity \_\_\_\_\_  
Treatment \_\_\_\_\_

Other Allergies Yes\_\_ No\_\_ Describe: \_\_\_\_\_  
Reaction and Severity \_\_\_\_\_  
Treatment: \_\_\_\_\_

Diet restrictions: Does your child have any diet or food restrictions? (Vegetarian, lactose, etc.) Yes\_\_ No\_\_

If yes, Please  
explain \_\_\_\_\_

Surgery: Has your child had any surgeries in the last year? Yes\_\_ No\_\_

If yes,  
explain \_\_\_\_\_

Date of Last Tetanus shot  
\_\_\_\_\_

Has your child had the chicken pox/vaccination? Disease Yes\_\_\_\_ No\_\_\_\_ Vaccination Yes\_\_\_\_  
No\_\_\_\_

Medical Background: Indicate if the camper has experiences any of the following medical conditions:

Heart Condition \_\_\_ Bedwetting \_\_\_

Eating Disorders \_\_\_ Seizures \_\_\_

Visual Difficulties \_\_\_ Digestive Problems\_\_\_

Hearing Difficulties \_\_\_ Asthma \_\_\_

Frequent Ear Infections\_\_\_ Emotional/Behavioral Concerns

ADD/ADHD(attention deficit) Diabetes \_\_\_

Urinary Infections \_\_\_ Headaches/Migraines \_\_\_

Other \_\_\_

Please explain as required \_\_\_\_\_

Have there been recent household adjustments or changes? (e.g. death of someone close or a family pet, illness, moving, new sibling, separation, divorce, etc.)

Is there any other information that you feel we should know about your child?

**These Permissions must be signed for Attendance**

"In permitting my child to attend Maritime Adventures Camp, I permit my child to participate in the full range of camp activities and authorize the Registered Nurses, or the Camp Director, in the event of accident or illness affecting this above named camper to authorize on my behalf all procedures, including admission to hospital and necessary treatment therein, as he/she may deem essential for the care and well-being of the camper. Such action is only to be taken when immediate contact with the identified emergency contact(s) cannot be made. It is understood that the camp is not responsible for the cost of medical care." "I authorize the camp nurse to administer medications to my camper that were sent with him/her at the recommended interval described on this registration form and prescription bottle or medications prescribed by the advising physician. All prescription bottles must be in English."

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Consent for the Administration of epinephrine ("Epipen") in the case of a Severe Allergic Reaction**

In the event of an unexpected severe allergic reaction (anaphylaxis) that may befall my child, hereby authorize the administration of the appropriate dose of epinephrine (determined by weight) by means of an Epinephrine Autoinjector or "Epipen" if deemed necessary by assessment by any one or all of the registered nurses in attendance at Maritime Adventure Camp. I also realize that if this medication is given, my child will be transported to the nearest Health Care facility via ambulance for assessment and treatment by a physician.

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**To prevent disappointment to your child, we suggest you have your child's head checked for lice prior to camp. If your child fails the registration head check for lice, they WILL NOT be permitted to stay. If your child has been in contact with anything communicable (ex: impetigo, hand/foot/mouth disease) please notify your local clinic prior to camp.**