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_________________________________
____
Home Phone#__________________________
Work Phome #_________________________
Cell Phone #___________________________
Other #_______________________________

Parent #2___________________________
Address (if different)__________________
____
Home Phone #________________________
Work Phone #________________________
Cell Phone #__________________________
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, labeled 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 ___

Eating Disorders ___

Visual Difficulties ___

Hearing Difficulties ___

Frequent Ear Infections___

ADD/ADHD(attention deficit)

Urinary Infections ___

Bedwetting ___

Seizures ___

Digestive Problems___

Asthma ___

Emotional/Behavioral Concerns

Diabetes ___

Headaches/Migraines ___

Other ___

Please explain as required____

____

____

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

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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 <u>WILL NOT</u> 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.