

Camp use only

Session: \_\_\_\_\_

Kvutza: \_\_\_\_\_

## **HABONIM DROR CAMP MIRIAM 2010 MEDICAL FORM**

**PLEASE NOTE: FAILURE TO RECEIVE THE COMPLETED MEDICAL FORMS BY APRIL 26<sup>TH</sup> WILL RESULT IN CANCELLATION OF THE CAMPER'S REGISTRATION AND FORFEITURE OF THE DEPOSIT.**

This form **MUST** be filled out for camper registration to be completed. Please complete as fully as possible. The sole purpose of these forms is to obtain the necessary information to better care for your children at camp. This information will be kept confidential. Parents are asked to photocopy the completed medical form and retain it for their records.

Campers are expected to fully participate in the program, which sometimes may be strenuous. In the past years, children have arrived at Camp with pre-existing medical and/or psychiatric behavioral conditions, which were not documented on the medical form. Sometimes these conditions inhibit the child's ability to participate in the camp program. When this occurs, the camp staff may be unprepared to properly care for the children. **INCOMPLETE INFORMATION COULD BE DANGEROUS TO YOUR CHILD. WE MUST BE NOTIFIED OF ALL CHANGES TO THE CAMPER'S MEDICAL STATUS IN ADVANCE . INCOMPLETE DISCLOSURE OF ANY MEDICAL, PSYCHIATRIC AND/OR BEHAVIORAL PROBLEMS MAY RESULT IN A CAMPER BEING SENT HOME FROM CAMP WITHOUT REFUND.**

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Male/Female: \_\_\_\_\_  
Day      Month      Year

Address: \_\_\_\_\_  
Number & Street                      City & Province                      Postal Code

Mother's Name: \_\_\_\_\_ Tel. (H) \_\_\_\_\_ (W) \_\_\_\_\_ (cell) \_\_\_\_\_

Father's Name: \_\_\_\_\_ Tel. (H) \_\_\_\_\_ (W) \_\_\_\_\_ (cell) \_\_\_\_\_

Child resides with whom? : \_\_\_\_\_

If parents not available in emergency call: \_\_\_\_\_

(H): \_\_\_\_\_ (O): \_\_\_\_\_ (Cell): \_\_\_\_\_

Provincial Medical Insurance Number: \_\_\_\_\_

Insurance carrier if not B.C. resident: \_\_\_\_\_

Policy # \_\_\_\_\_ ID # \_\_\_\_\_

Name: \_\_\_\_\_

Parents/Guardians to complete this section of the medical form

**General symptoms:**

Indicate what, if any, medical condition/diagnosis is present: \_\_\_\_\_

In addition to the above, does this camper have any problems with the following:

Please circle the correct answer:

Hearing	Yes	No	Dizziness	Yes	No
Headaches	Yes	No	Ear infections	Yes	No
Tonsillitis	Yes	No	Chest infections		
Abdominal pain	Yes	No	(Asthma / Bronchitis)	Yes	No
Diarrhea	Yes	No	Constipation	Yes	No
Bedwetting	Yes	No	Bladder infections	Yes	No
Seizures	Yes	No	Fainting spells	Yes	No
Pain in any			Sleep walking	Yes	No
bones or joints	Yes	No	Eating Disorders	Yes	No
Nose bleeds	Yes	No	Homesickness	Yes	No
Keloid healing	Yes	No	Behavioral problems	Yes	No
Learning disorders	Yes	No	Suicidal/Self Harm		
Alcohol / Drug Use	Yes	No	feelings	Yes	No
Lice	Previous	Current			

Medical conditions not included above? (Diabetes, Arthritis, Asthma etc.) Please list and elaborate: \_\_\_\_\_

Please elaborate on any of the "Yes" answers above and include any information, which would be helpful in caring for your child (may use an additional sheet of paper): \_\_\_\_\_

Prior operations , hospitalizations, accidents, injuries? Please List: \_\_\_\_\_

Current treatment and medication? Please List: \_\_\_\_\_

Planned medication while at camp:

\_\_\_\_\_ dosage frequency

\_\_\_\_\_ dosage frequency







**The following section to be completed by a physician**

Please complete this form as fully as possible. Please print clearly.

Have you reviewed and verified the information compiled by this patient’s parent or guardian?  
yes

**Patient name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Physical examination:**  
normal examination  
Positive physical findings: \_\_\_\_\_  
\_\_\_\_\_

**Medical Conditions/Diagnosis:**  
Indicate what if any medical condition/diagnosis is present: \_\_\_\_\_  
\_\_\_\_\_  
Has this patient had surgery, hospitalization, accidents or injuries? If so, list dates:  
\_\_\_\_\_

Is there anything else about this patient that the camp doctor should be aware of?  
Medical or surgical conditions? \_\_\_\_\_  
\_\_\_\_\_

Are there now, or have there ever been, any psychiatric or behavioral conditions, including eating disorders, suicidal behavior, alcohol or drug use, or depression that you are aware of?  
\_\_\_\_\_

Patient name: \_\_\_\_\_

**Serious Allergic Reactions:**

Bee/Wasp stings: \_\_\_\_\_

other foods: \_\_\_\_\_

Nuts: \_\_\_\_\_

medications: \_\_\_\_\_

other: \_\_\_\_\_

Allergy: \_\_\_\_\_ Type of reaction (symptoms): \_\_\_\_\_

Treatment: \_\_\_\_\_

Allergy: \_\_\_\_\_ Type of reaction (symptoms): \_\_\_\_\_

Treatment: \_\_\_\_\_

**Any camper carrying an epipen should have their status reviewed by an allergist prior to camp**

Has this patient been to any health care specialists regarding any psychiatric or behavioral conditions (e.g. psychiatrist, psychologist, counsellors, social worker, music or art therapist, etc.)? \_\_\_\_\_

Would you recommend any restrictions on this patient's activities? \_\_\_\_\_

Are there any specific diet recommendations for this patient? \_\_\_\_\_

Patient name: \_\_\_\_\_

**Regular Medications:**

**This patient requires regular medication and she/he will bring them to camp**

List name, dosage and frequency: \_\_\_\_\_

List name, dosage and frequency: \_\_\_\_\_

List name, dosage and frequency: \_\_\_\_\_

**This child requires PRN medications and she/he will bring them to camp**

List name, dosage and frequency: \_\_\_\_\_

List name, dosage and frequency: \_\_\_\_\_

List name, dosage and frequency: \_\_\_\_\_

Has this child ever been on medications for behavioral, sleep, learning or psychiatric problems? If so, does the child have a drug holiday? Have there been any recent or planned changes to the number, type or dosage of medications? :

\_\_\_\_\_

Are you the patient's regular doctor? Yes No If yes, please indicate the date of first consultation: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Physician's Name (PRINT) Address ( ) Phone Number

Please attach any consultations or reports that may be helpful in caring for this patient at camp.

## The Habonim Dror Camp Miriam Medical Release

I, \_\_\_\_\_ parent/guardian of \_\_\_\_\_  
hereby authorize the physician selected by the camp director or his/her designate to provide any  
medical attention necessary for the health and safety of my child.

I authorize the use of an epipen to administer epinephrine in the event of a suspected  
anaphylactic reaction. I understand that this may occur prior to a physician's assessment on an  
emergency basis only.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Insurance Number: \_\_\_\_\_

EMERGENCY PHONE NUMBERS TO CONTACT YOU DAY AND NIGHT:

MOTHER: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (CELL) \_\_\_\_\_

FATHER: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (CELL) \_\_\_\_\_

If parents or guardians will be unavailable during camp season, please indicate alternative  
emergency contact.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Numbers:

(H) \_\_\_\_\_ (W) \_\_\_\_\_ (CELL) \_\_\_\_\_

**PLEASE RETURN MEDICAL FORM TO:**

**CAMP MIRIAM  
#303 – 950 WEST 41<sup>ST</sup>  
VANCOUVER, BC V5Z 2N7**

**OR:  
FAX: 1-866-623-7721**