Camp Lumbini Medical Information Form

The following information will be helpful to the supervisor/chaperone in making your child/ward comfortable and safe.

Full Name: _____ Date of Birth: _____

Parent/Guardian: _____ Telephone: (H) _____ (Mobile) _____

Ontario Health Number: _____ Family Doctor: _____ Telephone: _____

Medical Conditions

Please indicate any significant medical conditions, physical limitations, or any other concerns that might affect your child's/ward's full participation in excursion activities.

❑ Asthma	❑ Fainting Spells	❑ History of head injuries	❑ Rheumatic Fever
❑ Chronic Nosebleed	❑ Feet or Leg problems	❑ Migraine	❑ Seizures
❑ Diabetes	❑ Hemophilia/Bleeding disorders	❑ Rash	❑ Sleepwalking
❑ Digestive upsets	❑ Heart problems	❑ Recent illness or operation	❑ Urinary infections
❑ Ear, Nose, Throat infections	❑ Hernia	❑ Other_____	

❑ Dislocated shoulder; swollen, painful joints; 'trick or lock' knee or other joint disability

Give details of usual treatment for each of the above conditions indicated: _____

_____

Please explain if your child/ward has any medical condition that requires any modification of his/her program. _____

_____

Allergies/Asthma

Please list all known confirmed allergies to the following:

(a) Foods: _____

If foods are life-threatening, please explain the symptoms and the treatment: _____

_____

(b) Medications: _____

(c) Other (e.g., bee or wasp stings, environmental allergies): _____

Has your child/ward suffered any serious allergic or asthmatic reaction?

If so, please provide details, including the type and severity of reaction: _____

Is allergy considered: Mild____ Moderate____ Serious____ Life-Threatening____

Has a doctor prescribed an Epi-Pen for your child/ward? Yes____ No____

Has a doctor prescribed an inhaler for asthma? Yes____ No___ (Prescribed asthma inhalers must be carried by the individual on the excursion.)

Has a doctor prescribed an inhaler for any other reason? Yes____ No____

Dietary Restrictions

Please list any foods your child/ward should not eat for medical, dietary, or religious reasons: _____

_____

Medication

Does your child/ward take prescribed medication on a regular basis? Please specify: _____

What prescribed medication(s) should your child/ward have with him/her during the excursion? _____

General

(1) Does your child/ward wear or carry medical alert identification (e.g., bracelet)? Yes____ No____

If yes, please specify what is written on it: _____

(2) Does your child/ward have any other relevant medical condition that will require modification of the program? Yes____ No____

If yes, please explain: _____

(3) Does your child/ward have any special fears or conditions (e.g., anxiety, bed-wetting, nightmares), the knowledge of which will allow the supervisor to make the individual's excursion more relaxed? Yes____ No____ If yes, please explain: _____

Should it become necessary for my child/ward to have medical care, I hereby give the supervisor/chaperone permission to use her/his best judgment in obtaining the best of such service for my child/ward. I also understand that in the event of such illness or accident, I will be notified as soon as possible.

Name of Parent/Guardian: _____ *(Please print)*

Name of Participant if over 18 years of age

Signature of Parent/Guardian: _____ Date: _____

Signature of Participant if over 18 years of age