CAMPER MEDICAL FORM

PLEASE COMPLETE THIS FORM FRONT AND BACK, TO THE BEST OF YOUR KNOWLEDGE.
PLEASE SUBMIT MEDICAL FORM ON OR BEFORE DAY OF REGISTRATION.

WHEN REGISTERING, UPON ARRIVAL, IT IS IMPERATIVE THAT YOU CHECK IN WITH YOUR CAMPER AT OUR FIRST AID STATION.

THIS SECTION TO BE COMPLETED BY PARENT OR GUARDIAN

Camper's Name_____ Sex M_____ F_____
(last) (first) (initials)

Full Mailing Address _____ City_____

Province/State _____ Postal/Zip Code _____ Phone( )_____

Birthdate_____/_____/_____ AGE_____ Healthcard#_____ Version_____
M D Y

Out of Country Insurance _____
(if applicable)

Parent or Guardian name_____ Relationship_____

Phone( ) _____ ( )_____ ( ) _____
(home) (business) (cell)

Parent or Guardian name_____ Relationship_____

Phone( ) _____ ( )_____ ( ) _____

If parent or guardian not available, in case of emergency, please contact:

Name _____ Relationship _____

Phone( ) _____ ( )_____ ( ) _____
(home) (business) (cell)

MEDICAL INFORMATION:

Has the camper been exposed to any communicable diseases within the three weeks prior to camp attendance? Yes_____ No_____

Date of Last Tetanus Booster (dptp 4-6yrs: dtp 14-16yrs) _____

Name of Family Physician_____ Phone( ) _____

Camper's present state of health:

Please check if the camper has or has had any of the following: □

○ Asthma	○ ADD/ADHD	○ Appendicitis	○ Bed-wetting
○ Chicken Pox	○ Diabetes	○ Eating Disorder	○ Epilepsy/fainting
○ Frequent colds	○ Frequent ear infections	○ Hay fever	○ Head Aches
○ Heart Condition	○ Hepatitis	○ Lactose Intolerant	○ Measles
○ Mumps	○ Nosebleeds	○ Rheumatic Fever	○ Severe stomach aches
○ Sinusitis	○ Sleepwalking	○ Toothache	○ Tonsillitis
○ Whooping Cough	○ Other: _____		

Allergies: Medication_____ Food_____

Insect Stings_____ Carry an Epipen? Yes_____ No_____

Other _____

* Special medication, dosage and when it should be taken. Please ensure all medication is in the original container. Prescription drugs **must** be in the original pharmacy container.

Identify requirements for Special Care while at Camp. List: Medication and Dosage, Treatments.	Daily Schedule				Weekly: Please specify day	Other : Please specify	Reason for Treatment
	8 am	Lunch	Dinner	Bed			

Special diet (ie: lactose intolerant, vegetarian, etc.) _____

_____

Camper may participate in: Swimming _____ Physical activity _____

Other suggestions from parents _____

_____

_____

I confirm that all the information supplied on this form is complete and correct.

I give consent for the Ranch first-aid staff to administer to my camper non-prescription medication such as Tylenol, antihistamines, Gravol, cough medicine, etc., if the need arises.

I give consent for the Ranch first-aid staff to obtain and approve any emergency medical attention, which may reasonably appear necessary to my camper's welfare and good health.

I certify that this camper is in good health and/or has been seen by a physician prior to attending this present camp week.

Name of parent or guardian: (Please print) _____

**Signature of parent or guardian: _____ Date_____

We do not charge for minor medical attention performed by Camp staff. In the case of serious accident or illness, the services of a hospital, physician, dentist or any other related service (i.e., EMS) will be acquired and the charges will be made to the camper's parents/guardians. Every reasonable attempt will be made to contact parents/guardians prior to services, wherever possible.

We will make every effort to ensure that your child does not have a food allergy reaction while at Rocky Ridge. We are not a peanut-free location (although all known peanut products are removed from our kitchen). Our goal is to help your child self-manage his/her condition.

RETURN ADDRESS - ROCKY RIDGE RANCH 10486-5TH LINE R.R.#2 ROCKWOOD ON N0B 2K0
PHONE (905)854-2584 **FAX/PHONE (905)854-0964**
E-MAIL info@rockyridgeranch.org **WEBSITE www.rockyridgeranch.org**