

Confidential Health History Form

Appendix B

YLCC Orillia

YLCC Pigeon Lake

We do not require participants to undergo a third party physical examination, but we do encourage all families have a proactive health plan, including regular physical examinations by your family doctor.

School/Group Name: _____

Student's Name	Birth Date (M/D/Y) <input type="checkbox"/> Male <input type="checkbox"/> Female																		
Home Address (city, province, postal code)	Home Phone																		
Parent/Guardian	Work Phone																		
Emergency Contact (if unable to reach parent/guardian)	Phone																		
Family Physician	Phone																		
<p>Does your child have any concerns with the following? Please check all that apply.</p> <table border="0"> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Environmental Allergies</td> <td><input type="checkbox"/> Medication Allergies</td> </tr> <tr> <td><input type="checkbox"/> Allergy to insect stings</td> <td><input type="checkbox"/> Food Allergies</td> <td><input type="checkbox"/> Seizures</td> </tr> <tr> <td><input type="checkbox"/> Hearing Loss</td> <td><input type="checkbox"/> Sleep Walking</td> <td><input type="checkbox"/> Diabetes</td> </tr> <tr> <td><input type="checkbox"/> Heart Problems</td> <td><input type="checkbox"/> Bed Wetting</td> <td><input type="checkbox"/> Skin Conditions</td> </tr> <tr> <td><input type="checkbox"/> Physical Disability</td> <td><input type="checkbox"/> Dietary Needs</td> <td></td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other _____</td> </tr> </table>		<input type="checkbox"/> Asthma	<input type="checkbox"/> Environmental Allergies	<input type="checkbox"/> Medication Allergies	<input type="checkbox"/> Allergy to insect stings	<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Seizures	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Sleep Walking	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Skin Conditions	<input type="checkbox"/> Physical Disability	<input type="checkbox"/> Dietary Needs		<input type="checkbox"/> Other _____		
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Please detail any of the above concerns, limitations, medications, recent illnesses, operations, or injuries.																			
Date of last tetanus shot:	Health Card Number:																		
<p>List any medications that your child must take on a regular schedule. <i>(please supply in their original containers)</i></p> <p>Name of Medication _____ Dosage _____</p> <p>How Often _____ When _____</p> <p><i>All medications must be placed in a clear zip lock bag, clearly labelled with camper's name and given to our Camp Health Director upon arrival.</i></p>																			

In permitting my child _____ to attend Youth Leadership Camps Canada, operated by YLCC Inc., I the undersigned permit my child to participate in the full range of camp activities and trips and authorize the Camp Director and his/her appointee, in the event of accident or illness affecting the 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 to be taken only when immediate contact with the undersigned cannot be made. I understand that the pictures taken at camp may be used for promotion. I fully understand all the risks involved in my child's participation in Youth Leadership Camps Canada programs and accept full liability. I have chosen to provide the above personal information to YLCC and understand that YLCC may send further leadership information to me in the future.

Signature of Parent/Guardian: _____ Date: _____

