

GUELPH BIBLE CONFERENCE CENTRE

Camper Medical Form

****PLEASE BRING THIS FORM TO CAMP AT TIME OF ARRIVAL****

CAMPER INFORMATION

Camper Name _____ Gender: M F
Surname First
Mailing Address _____ Birthdate: (MM / DD / YY)
Apt _____ City _____ Age: _____ (As of December 31, 2008)
Prov./State _____ Postal Code _____ Telephone (_____) _____

HEALTH CARD NUMBER

Health Card Number - _____

CONTACTS

	Name	Home Phone	Business	Cell	Relationship
Primary:	_____	(____)_____	(____)_____	(____)_____	_____
Secondary:	_____	(____)_____	(____)_____	(____)_____	_____

Name of Physician: _____ Phone # _____

HEALTH HISTORY

Medical Conditions None

<input type="checkbox"/> Hepatitis B, C	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Seizures
<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Visual Problems	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Crohns
<input type="checkbox"/> Mouth Injuries	<input type="checkbox"/> Asthma/Inhalers	<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Downs Syndrome	<input type="checkbox"/> Developmental Delays	<input type="checkbox"/> Behavioural Issues	<input type="checkbox"/> Cancer
<input type="checkbox"/> Mental Health Issues	<input type="checkbox"/> Colitis	<input type="checkbox"/> Other _____	

Current Problems None

<input type="checkbox"/> Constipation	<input type="checkbox"/> Homesickness	<input type="checkbox"/> Nightmares/Terrors	<input type="checkbox"/> Headaches
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Sinus Infections	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Sleepwalking
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Stomach Aches	<input type="checkbox"/> Sore Throats	
<input type="checkbox"/> Other _____			

Surgical History (please insert date beside surgery) None

<input type="checkbox"/> Heart	<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Ear Tubes	<input type="checkbox"/> Orthopedic
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Other _____	

Allergies None

Drugs Food Environmental (if bee sting – please bring own EpiPen)

Give brief details re: Allergies - _____

MEDICATION

If camper is on medication, a doctor's signature is required

Medication: _____ Reason For Treatment: _____

Doctor's Signature: X _____ Date: _____

CONSENT

I have read this form thoroughly and to the best of my knowledge the information is correct. I hereby consent to give the camp director, in case of emergency, the right to take my child as warranted, to the facility as warranted, in the best interests of the camper. Before emergency treatment at a hospital is given, every effort will be made to contact the parent/guardian. While every precaution shall be taken to ensure the welfare and protection of the camper, Guelph Bible Camp, its Directors and staff are hereby released from any liability in the event of accident or misfortune that may occur to the camper. To the best of my knowledge, my child is in good health. I will notify the camp by written document if my child is exposed to an infectious disease or there is a change in health during the weeks prior to arriving at camp.

Name of Parent/Guardian (please print)

X _____
Signature of Parent/Guardian

Date