

Montreal Boys' Choir Course 2012

Health Certificate

PLEASE PRINT

SECTION 1: PARTICIPANT										
Family name				Given name			Age at July 29, 2012			
Medicare OHIP Health Care no.				Date of birth			Year	Month	Date	

SECTION 2: EMERGENCY CONTACT											
Family Relationship <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other				Family name			Given name				
Area code			Telephone (primary)			Area code			Telephone (Secondary)		
				Email							

SECTION 3: INSURANCE INFORMATION										
Insurance company				Policy No.			Group No.			
Policy Holder Name				Relation to camper						

SECTION 4: HEALTH HISTORY											
Known allergies	<input type="checkbox"/> Medication	<input type="checkbox"/> Food	<input type="checkbox"/> Insect bites	<input type="checkbox"/> Smoke	If you've checked any of the boxes, please give details						
	<input type="checkbox"/> Toxins	<input type="checkbox"/> Plants	<input type="checkbox"/> Animals	<input type="checkbox"/> Others							
Can camper recognise when he is having an allergic reaction?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the camper carry an ANA kit?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the camper carry an EIPEN?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Previous illnesses	<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Measles (red)	<input type="checkbox"/> Kidney disease	If you've checked any of the boxes, please give details						
	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Mumps		<input type="checkbox"/> Other					
Currently suffering from	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	If you've checked any of the boxes, please give details						
	<input type="checkbox"/> Migraines	<input type="checkbox"/> Motion sickness	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Enuresis		<input type="checkbox"/> Other					
Date of most recent physical		Year		Month		Date of last tetanus shot		Year		Month	
To the best of my knowledge, my child is in good health. I will notify the camp if my child is exposed to an infectious disease during the three weeks prior to arriving at camp. The camp nurse has my permission to administer the medication as listed on back of the health care form. In case of emergency, I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician, selected by the Camp Director and/or Camp Nurse to hospitalize, secure proper treatment, order injection, anaesthetic or surgery for my child										Signature of parent/guardian	

SECTION 5: MEDICATION (Prescribed and non-prescribed)									
To ensure the health and safety of all, medications brought to camp shall be the responsibility of the health staff and must be presented at registration. Medications cannot be administered unless the authorization below has been completed and signed. In the case of non-prescription medications, the signature of a parent/guardian is adequate. This includes non-prescription medications supplied by the Choir Course (such as Aspirin™, Graval™). Medications to be given upon the order of a physician require authorization by him/her in writing and the chorister should have in his possession enough medication for the duration of the camp. NOTE: Campers with Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) are encouraged to bring their medication as the course requires hours of focusing.									

PRESCRIPTION MEDICATION					NON-PRESCRIPTION MEDICATION (Over-the-counter — such as Graval™, Tylenol™, Claritin™)						
<input type="checkbox"/> I hereby give my consent for the administration of the following medication(s) to my son while he is attending the course.					<input type="checkbox"/> I hereby give my consent for the administration of the following medication(s) to my son while he is attending the course.						
Name			Name			Name			Name		
Given for			Given for			Given for			Given for		
Side Effects			Side Effects			Side Effects			Side Effects		
Comments			Comments			Comments			Comments		

Date de réception			Signature			Date de remise			Signature		
Année	Mois	Jour				Année	Mois	Jour			