Ontario Parks & Recreation Summer Day Camp
CAMPER’S HEALTH RECORD

THIS FORM IS TO BE RETURNED UPON REGISTRATION TO: ONTARIO PARKS & REC. DEPT.

Name
Address
Street
Town
State
Zip
Phone #
DOB
Gender: M or F
Grade
Age
(Mother’s Name)
Work phone #
(Mother’s Employment)
(Father’s Name)
Work phone #
(Father’s Employment)

If not available in an emergency, please notify:
Name
Relationship
Phone #
Address

Are there limitations on who may pick up the camper after each session?

MEDICAL HISTORY

Family Physician
Dentist/Orthodontist

Date of last physical exam
Date of last dental exam

***Answer using:
N = No
P = Past
R = Recent
X = Recurring
***

- Respiratory/Sinus Infections
- Ear Infections
- Motion Sickness
- Diarrhea/Vomiting/Cramps
- Liver Disorders
- Hernia
- Urinary Tract Infections
- Nervous Disorders
- Epilepsy
- Arthritis or Joint Injuries
- Chicken Pox
- Measles
- Convulsions/Seizures
- German Measles
- Mumps
- Emotional/Behavioral Problems
- Heart Disease/Rheumatic Fever
- Head Lice
- Abnormal Blood Pressure
- Bleeding/Clotting Disorders
- Menstrual Problems
- Migraines/Headaches

CURRENT MEDICAL PHYSICAL LIMITATIONS

Answer using
Y = Yes
N = No

- Eyesight Impairment
- Corrective Lenses
- Hearing Impairment
- Speech Impairment
- Learning Disability
- Asthma
- Phobias/Fears
- Tuberculosis
- Sun Sensitivity
- Diabetes/Abnormal Blood Sugar
- Does camper carry inhaler, injectable substances?

Allergic to:
- Bee/ Wasp
- Pollen / Plants
- Poison Ivy
- Animals
- Milk
- Sulfites
- Other Foods
- Aspirin
- Penicillin
- Other Drugs/Substances

Describe Allergic Reaction

- Other Chronic/Recurring Illness
- Recent operation or sutures
- Recent Exposure to contagious Disease
- Current or past physical therapy
- Currently taking medication or therapy or receiving medicine or treatments

Explanations or Details for any: yes, recent or recurring answers:
IMMUNIZATIONS HISTORY

Please provide at least, month & year for each vaccine

(Diphtheria, Pertussis & Tetanus)
DPT -  First________ Second_________ Third_________
DT -  First________ Second_________ Third_________

Last Booster (either DPT or DT) First_________

Polio  First________ Second_________ Third_________

Measles________ Mumps________ Rubella_________

RESTRICTIONS  Answer   Y – Yes    N – No
Dietary
Endurance Sports (Soccer, jogging, etc.)  
Water Sport  Stress Sports (Sprint races, etc.)
Hiking  Archery  Overnight Camping  
Contact Sports (Football, wrestling, etc.)  

Other activities

Explanation for YES answers ___________________________ 

INFORMATION FOR COUNSELORS

Favorite Activities____________________________________
Disliked Activities____________________________________
Recent change in camper’s life (family move, divorce, etc.)

INSURANCE

Is camper covered by medical/hospitalization insurance?__________________
If yes, carrier:________________________ Policy/Group #: __________________

Does policy require approval of primary care (family) physician or medical group prior to treatment?
If yes, Phone #________________________

PARENT’S / GUARDIAN’S EMERGENCY AUTHORIZATION

To the best of my knowledge, the information provided on this health form is correct and this camper has permission to engage in all camp activities, except as noted by me.

I hereby give permission for the medical personnel selected by the camp director to treat my child for all illness/injury and to order x-rays and routine test as necessary. In the event I cannot be reached in an emergency, I give permission to the physician chosen by the camp director or camp medical director to secure proper treatment for, to hospitalize and to order sutures, injections, anesthesia, surgery, tests, x-rays or other treatments as medically appropriate for my child.

I agree to be responsible for any medical bills resulting from illness or injury during my child’s attendance at camp.

_________________________  __________________________
Date  Parent \ Guardian Signature