

MADAWASKA

volleyball & all-sport camps

P.O. BOX 70570 • 1801 DUNDAS STREET EAST,
 WHITBY, ONTARIO, L1N 9G3
 Toll Free: 1.866.553.0655 • Fax: 905.438.8801
 website: www.madawaskacamps.com
 email: info@madawaskacamps.com

HEALTH FORM

To ensure that campers are permitted to participate in all camp activities, please complete this form and return it to our office before July 1st. This form must be completed by a parent/guardian when athletes are younger than 18 years of age.

NAME: _____ HEALTH CARD NUMBER: _____

TELEPHONE: _____

IMMUNIZATION RECORD DATE OF LAST INJECTION	ALLERGIES PLEASE SPECIFY	MEDICATIONS INDICATE DOSAGE AND TIMES
<input type="checkbox"/> Diptheria / Tetanus/ Polio / Pertussis: _____ <input type="checkbox"/> TB: _____ <input type="checkbox"/> Measles / Mumps / Rubella: _____ <input type="checkbox"/> Chickenpox: _____ <input type="checkbox"/> Hepatitis B: _____ <input type="checkbox"/> HIB: _____	<input type="checkbox"/> EpiPen Needed: _____ Reason: _____ <input type="checkbox"/> Animals: _____ <input type="checkbox"/> Foods: _____ <input type="checkbox"/> Drugs: _____ <input type="checkbox"/> Other: _____	

Please state any dietary restrictions:

Please list any restriction to camp activities:

Please list any medications being discontinued during your camp session:

Please list any recent operations, illnesses, or injuries:

Please state any physical or emotional concerns:

To the best of my knowledge, the athlete is in good health and has not been exposed to any infectious diseases in the past four weeks. If he or she became exposed to any infectious diseases, or any change in health status, between now and the beginning of the camp session, I understand that the camp must be notified in writing. In case of an emergency and we are not available for consultation, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injections, anaesthesia, or surgery for my child as named above. I have disclosed all pertinent information including information regarding prescription medications. I hereby give permission to allow my child's physician to give Madawaska Camps medical information about my child should it be required by the camp.

DATE

SIGNATURE OF ATHLETE OR PARENT/GUARDIAN

PLEASE SEND WRITTEN NOTIFICATION OF CHANGES AFTER COMPLETION OF THIS FORM
 PLEASE ATTACH A NOTE IF YOU HAVE ADDITIONAL INFORMATION
 PLEASE RETURN THIS FORM BY FAX OR MAIL BEFORE JULY 1st