2015 RRBC Camper Health Medical Form

Please mail Registration together with Medical form to: Red Rock Bible Camp, 204 – 310 Main St, Steinbach, MB R5G 1Z1

This medical form must be **returned with the Camp registration form**.
Camper **will NOT be accepted** without it.

First name: _____ **Last Name**: _____ ❑ **M** ❑ **F**

Mailing Address/Town and Province: _____

Postal Code: _____ **Phone #:** _____ **Age**: _____

Birthday ____/ ____/ _____ **MHSC #:** ___ ___ ___ ___ ___ ___ **PHIN #**: __ __ __ /__ __ __ /__ __ __
dd mm yyyy

Camper's Doctor: _____ **Phone #**: _____

Session attending Camp: _____ **Dates attending:** _____

In case of Emergency:
Mother's Name: _____ Home #: _____ Work #: _____

Father's Name: _____ Home #: _____ Work #: _____

Phone # parent can be reached at during camper's stay at camp (if different than above): _____

Alternate contact person: _____ Phone#: _____

Relationship to camper (Please circle) Grandparent Aunt Uncle Friend Other _____

Health History:

Date of last physical exam: _____ Are immunizations up to date: ❑ Yes ❑ No

Date of last Tetanus shot: _____

Please list any allergies to food, medication or other (such as pollen, dust, pets etc.)

Allergy:	Reaction:	Treatment:

Asthma: ❑ No ❑ Yes, what triggers an attack? _____

Treatment: _____

If your child has asthma, or if your child has any allergic reactions that require medication or medical attention to treat it, please attach a treatment plan to the health form

NOTE: Red Rock's closest medical facility is about one hour from camp.

Is the camper subject to: (please check)

❑ ear aches ❑ bedwetting ❑ sore throat ❑ stomach aches ❑ cough ❑ frequent head aches ❑ migraines

❑ sleep walking ❑ eye problems ❑ seizure disorder ❑ other: _____

To assist the nurse in providing treatment for any of the above, please explain how you treat the condition (e.g. 1 Tylenol, rest, etc.) _____

Does the camper have any other current physical/psychological/emotional or behavioral conditions?
(e.g. Diabetes, epilepsy, attention deficit disorder, any phobias) Please list and explain treatment. _____

_____

_____

Activity restrictions ❑ No ❑ Yes, please explain. _____

_____

Females: menstruating ❑ Yes ❑ No Is aware of it's possible onset/concerns _____

Medications:

List any medication, dosage and time(s) camper is taking: _____

_____

_____

_____

_____

PLEASE NOTE: All medication must be sent to camp in the **ORIGINAL CONTAINER**. Please send a sufficient supply plus **detailed instructions** regarding the administration. Medications will be administered by the camp nurse.

****** I herewith give consent for the camp administration to secure medical treatment in the event of an emergency. I give permission for the medical staff to administer medication. I give permission for qualified staff to administer and Epi pen if needed. In such situations, the camp will attempt to notify the parents as soon as possible.

****** I the parent/guardian am responsible for any additional expense that may result from such services.

****** I will notify the camp in writing if any change occurs in the camper's health within 6 weeks prior to attending camp.

****** I certify that the information given in this medical form is complete and accurate to the best of my knowledge.

Parent/Guardian Signature: _____ **Date:** _____

Note: In the event of serious illness, accident or other emergency, parents/guardians will be contacted.

Medical Form must accompany Registration Form

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