



Camper Health Information Form

DO NOT fill out online or send to HMI - You must complete this form and BRING IT TO CAMP.

The purpose of this record is to provide HMI Christian Hockey Camps with information relating to any medical condition affecting the camper that would limit participation in or prevent him/her from engaging in camp activities. The disclosed information will be treated as confidential and will be made available only to those persons who, in the judgement of the camp administrators, should be made aware of the information or any part of it. As the activities in which the camper will be engaging are often physically demanding, **we require that a camper who is currently under a doctor's care for any medical condition (including asthma) or injury, or who must take prescription medication during the week of camp undergo a physical examination by a physician prior to attending camp. The physician should complete Part C of this form.** HMI Christian Hockey Camps assume that where appropriate, the parent/guardian of the camper has sought the advice of the camper's physician prior to arrival at camp. In any case in which such medical consultation has occurred, the recommendations of the consulting physician as to appropriate care, caution and/or restrictions should accompany this record. If the camper has no medical condition or injury and does not take prescribed medication, the parent/guardian may choose to check the box in Part B, giving consent in place of the physician, although, it is still highly recommended that your child have a physical examination prior to camp.

Part A: To be completed by the parent/guardian. (Please print.)

Camper's Last Name Camper's First Name.....
Birthdate (mm-dd-yyyy)
Camper's Social Security #(last 4 digits) (US) or Social Insurance # (CAN)(last 3 digits).....
Parent/Guardian's Last Name Parent/Guardian's First Name
Street address, City State/Prov, Zip Code/Postal Code

Phone Access During Camp:

Home # Cell # Work #
Additional Emergency #(after trying the above #ers, the additional emergency # will be called—please specify person's name at this # & their relationship to camper)

Health Care Information (Important Note: It is the responsibility of the parent/guardian to confirm out-of-country coverage, if applicable. If the camper is Canadian and also has private health insurance, please include the private health insurance information along with provincial health card #, otherwise just fill out what is applicable to your child).

Doctor's Name/Phone No.
Dentist's Name/Phone No.
Provincial Health Card # (Canadian campers only)Exp.Date (if applicable).....
Health Insurance #, Carrier, State/Prov., Exp. Date-if applicable (US campers & Canadian campers if applicable):
.....
Name of Policyholder (US campers & Canadian campers if applicable)
If insurance policy is provided by parent's employer, please indicate: Employer Name /Address
Policyholder Relationship to Camper

Health History and Current Health Conditions (Please circle the appropriate answer and provide details where necessary.)

Has the camper ever suffered from &/or currently suffers from:

Does the camper have allergies or intolerances or has the camper ever suffered from an allergic reaction to:

| | | | | | | | | |
|-------------------------------|-----|----|----------------------|-----|----|---------------------------------------|-----|----|
| Asthma | Yes | No | Convulsions | Yes | No | Food Products | Yes | No |
| Athletic Injuries | Yes | No | Diabetes | Yes | No | Hay Fever | Yes | No |
| Bedwetting | Yes | No | Ear Infections | Yes | No | Insect Stings | Yes | No |
| Behavioral Problems | Yes | No | Epileptic Seizures | Yes | No | Medication | Yes | No |
| Broken Bones | Yes | No | Respiratory Problems | Yes | No | Other allergy (ies) or intolerance(s) | Yes | No |
| Head Injury (ies) (type/date) | Yes | No | Sleeping Problems | Yes | No | Does the camper carry an EpiPen? | Yes | No |

If you indicated "Yes" for any of the above, please give a detailed explanation below & continuing on the dotted lines on page 2, including activity restrictions, treatment requirements and current medications. Please specify any other significant past medical history or current medical conditions that our medical staff should be aware of. Attach a separate sheet if necessary.

.....

Camper Name _____

Does the camper have a history of drug abuse (illegal, prescribed or over the counter) ? Yes No If yes, please explain:

Does the camper have a history of tobacco use? Yes No If yes, please explain:

Does the camper have a history of alcohol use? Yes No If yes, please explain:

*****WE HAVE A ZERO TOLERANCE POLICY FOR DRUGS, TOBACCO OR ALCOHOL AT OUR CAMPS.*****

Part B: To be completed by the parent/guardian. (Please print.)

IMMUNIZATION STATUS (Please provide year and month of immunization. **List or attach all vaccine dates.**)

| <i>Immunization</i> | <i>Date 1</i> | <i>Date 2</i> | <i>Date 3</i> | <i>Date 4</i> | <i>Date 5</i> |
|--|---------------|---------------|---------------|---------------|---------------|
| Measles/Mumps/Rubella (MMR) | | | | | |
| Polio (OPV / IPV) | | | | | |
| Varicella (Chicken Pox) or date of disease | | | | | |
| Hemaphilus Influenza B (HIB) | | | | | |
| DTP / DTaP | | | | | |
| Tetanus Booster (Td) | | | | | |
| Hepatitis B | | | | | |
| Meningococcal Vaccine | | | | | |

DIETARY ACTIVITY & OTHER RESTRICTIONS that must be followed precisely to ensure the well-being of the camper:

MEDICATIONS (not previously documented) that the camper is required to take:

Type Dosage/Freq..... Duration of Treatment
Type Dosage/Freq..... Duration of Treatment

Parental Authorization:

To the best of my knowledge, this health history is fully correct in all details. The camper(camper's name)..... has my permission to engage in all prescribed camp activities except as noted above and/or over. I hereby authorize the staff of HMI Christian Hockey Camps to make any and all decisions regarding the emergency treatment of my child and to administer any prescribed medication. I also give permission to qualified health personnel (physician, nurse, other outside emergency medical/dental personnel, and/or staff who possess a current First Aid certificate) to provide treatment for my child. I understand that the camp is not responsible for medical/dental case costs.

I understand that HMI Christian Hockey Camps recommend that my child be examined by a physician prior to camp but I choose not to do this because my child is not currently on any medication, has no injuries, and does not have any current health conditions. I take full responsibility for this decision.

Signature Date (mm-dd--yyyy).....

Part C: To be completed by the camper's physician. (Please print.)

Name of Physician
Street Address, City State/Prov, Zip Code/Postal Code
Phone Number Date of Examination.....

Physician's Authorization:

I have examined this camper and checked the health information in Parts A and B. In my opinion, the camper is physically fit to engage in all prescribed camp activities except for the following:

Signature Date (mm-dd-yyyy).....