CAMP SQUEAH MEDICAL FORM - STAFF

#4 – 27915 Trans-Canada Hwy, Hope BC, V0X 1L3

Name: (as on health card) ____________________ **Birth Date:** ____________

Address: ____

Care Card / Health Ins. #: ____________________ **Provider**: ____________

Family Doctor: ____________________ **Dr's Phone:** ____________

In Emergency,
First Contact: ____________________ **Phone:** Primary ____________

Email: ____________________ Other ____________

Second Contact: ____________________ **Phone:** Primary ____________

(If First Contact unavailable) Other ____________

Medications: All medications, including "over the counter" medications (e.g. Tylenol, antihistamines, Lactaid, etc.) must be stored with First Aid Attendant. Medications must be in their original containers; labelled with the patient name, name of medication, dosage, etc.

Medication Name	Reason prescribed	Dosage

Tetanus: Is Tetanus shot up to date (within last 10 years)? **Yes** **No**
(If not, please have it done before camp.)

Special Dietary Restrictions, please be specific:

Allergies (Medications, Environmental, Food, and Other) and Reaction:

Information: Please provide any other information that would be helpful for the First Aid Attendant or Program Director to care for the individual, including medical, illnesses, physical limitations, or behaviors.

In the event of a minor medical occurrence, I/WE give permission for common "over the counter" preparations, such as pain relievers or antihistamines to be provided at the discretion of the First Aid Attendant.

I/WE further authorize the Director and/or Camp First Aid Attendant to seek all necessary medical attention in the event that the emergency contact person cannot be reached.

Staff/Volunteer Signature: ____________________ **Date:** ____________

Parent/Guardian Signature: ____________________ **Date:** ____________
(if under 19)