



SUMMER YOUTH CAMP

ARARAT SUMMER YOUTH CAMP – Aug 17-22, 2009
Counsellor/Staff Medical Form (18 YEARS OLD AND OVER)
Wesley Acres Retreat, Bloomfield, Ontario

Counsellor/Staff Name: \_\_\_\_\_ M: \_\_\_\_\_ F: \_\_\_\_\_ Date of Birth: (Mo.) \_\_\_\_\_ (Day) \_\_\_\_\_ (Yr) \_\_\_\_\_ Age @ Camp Time \_\_\_\_\_
Surname Initial First Name

Counsellor/Staff E-mail Address: \_\_\_\_\_

Address: \_\_\_\_\_ Apt#: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Father/Guardian Name: \_\_\_\_\_ Res. Tel. # \_\_\_\_\_ Bus. Tel.# \_\_\_\_\_ Cell # \_\_\_\_\_

Mother/Guardian Name: \_\_\_\_\_ Res. Tel. # \_\_\_\_\_ Bus. Tel.# \_\_\_\_\_ Cell.# \_\_\_\_\_

E-mail Address: Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Which Parent Can we Reach during the time you are at camp (Aug. 17-22)? Mother \_\_\_\_\_ Father \_\_\_\_\_ Telephone: \_\_\_\_\_

Emergency Contact Person & Telephone Number (Other than Parent/Guardian)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Tel. #s: \_\_\_\_\_

Confidential Medical Information

Health Card #: \_\_\_\_\_ Family Physician: \_\_\_\_\_ Physician Tel. #: \_\_\_\_\_

Date of last complete medical examination \_\_\_\_\_ Date of last tetanus immunization \_\_\_\_\_

Are you allergic to any drugs, foods, or medication? Yes / No
If yes, please provide details \_\_\_\_\_

Do you take any prescription drugs? Yes / No
If yes, please provide details \_\_\_\_\_

\*Please be advised that all medication, prescription or non-prescription, must be given to the head counsellor on the first day of camp. Medication will be administered to the child as directed, in writing.

Do you wear/carry a medical bracelet? \_\_\_\_\_ neck chain? \_\_\_\_\_ alert card? \_\_\_\_\_

Do you wear eyeglasses? Yes / No Contact lenses? Yes / No

Please indicate below if you have been subject to any of the following and provide pertinent details below:

Table with 3 columns: Condition, Yes, No. Rows: Epilepsy, Diabetes, Orthopedic Problems, Deaf.

Table with 3 columns: Condition, Yes, No. Rows: Hard of Hearing, Asthma, Allergies, Arthritis Rheumatism.

Table with 3 columns: Condition, Yes, No. Rows: Chronic nosebleeds, Dizziness, Fainting, Headaches.

Table with 3 columns: Condition, Yes, No. Rows: Hernia, Swollen/hyper mobile joints, Trick or lock knee, Hepatitis B or C.

Details of any "Yes" response above: \_\_\_\_\_

Any other medical information that will limit you to participate in camp activities as camp counsellor/staff: \_\_\_\_\_

I have sought competent advice with respect to my health and well being prior to completing this form. I agree to release the Canadian Diocese of the Armenian Church, Camp Ararat and its medical staff, other counsellors/staff and supervisors of any liability. In the case of an emergency, medical/ hospital services may be required for me. I understand that every reasonable effort will be made by the camp/hospital services to contact the emergency person listed above. This is your authorization to have medical personnel and/or hospital staff administer medical or surgical services, including anaesthesia and drugs to me. I understand that any costs relating to such medical services being required will be my responsibility.

Dated: \_\_\_\_\_ Signature of Counsellor/Staff (over 18 yrs old) -> \_\_\_\_\_
Print Name ->