



THE BANDCAMP

430-18 Concorde Place
 Don Mills, Ontario M3C 3T9
 tel./fax: 416.321.8996
 fun@TheBandCamp.ca
 Charity # RR 14073 7966 RR 0001

Camper Medical Form

We want The BandCamp experience to be the best it can be. Please be sure to fill out every detail on this Medical Form carefully; one form per child. If the form is not completed fully, we will send the form back to you for completion before registering your child. Please attach a school photo or headshot with name on back.

Camper: Last Name		First Name		<input type="checkbox"/> Male
				<input type="checkbox"/> Female
Home address: Street		City	Prov	Postal Code
				□ □ □ □ □ □ □ □
Birth date: yyyy-mm-dd	Age as of July 1st	Healthcard #		Issuing Province
□ □ □ □ - □ □ - □ □	□ □	□ □ □ □ □ □ □ □ □ □ □ □ □ □		□ □ □ □ □ □ □ □
Height:	Weight:	Immunizations up to date?		Date of last tetanus or DPT: yyyy-mm-dd
□ ft □ □ in	□ □ □ lbs	<input type="checkbox"/> Yes <input type="checkbox"/> No		□ □ □ □ - □ □ - □ □
		DPT, MMR, HIB, Hepatitis B, Meningitis		

Contact	Emergency Contact #1	Emergency Contact #2	Family Physician
	Name:	Name:	Name:
	Home Phone:	Home Phone:	Phone:
	Work Phone:	Work Phone:	Approx. date of last examination:
	Cell Phone:	Cell Phone:	
	<input type="checkbox"/> mother <input type="checkbox"/> father <input type="checkbox"/> guardian	<input type="checkbox"/> mother <input type="checkbox"/> father <input type="checkbox"/> guardian <input type="checkbox"/> other	We strongly encourage the camper to have a yearly physical check-up; one per year is covered by OHIP.

Allergy	Food Allergies: <input type="checkbox"/> no (circle or list:)	Environmental Allergies: <input type="checkbox"/> no	Drug Allergies: <input type="checkbox"/> no
	peanuts, nuts, lactose intolerant, shellfish, dyes	bee stings, pollen, dust/mold, dander, spiders	Penicillin, Sulpha, Codeine, Acetaminophen, Ibuprofen
	Other:	Other:	Other:
	Describe reaction:	Describe reaction:	Describe reaction:
Is allergy life threatening? <input type="checkbox"/> yes <input type="checkbox"/> no			
If yes, carries auto-injector? <input type="checkbox"/> no <input type="checkbox"/> AnaKit <input type="checkbox"/> Epi-pen <input type="checkbox"/> Twin-Ject Does child know how to use it? <input type="checkbox"/> yes <input type="checkbox"/> no			

Diet	Please indicate any special diet provisions for your child: (e.g. vegetarian, vegan, peanut-free etc.):	<input type="checkbox"/> no special diet
	provisions	

Conditions & Problems	Check any conditions that affect your child. Please indicate any other health concerns and/or restrictions below:									
	<input type="checkbox"/> None	<input type="checkbox"/> Behavioural Concerns	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Mental Health Issues	<input type="checkbox"/> Sleep Walking					
	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hearing Difficulty	<input type="checkbox"/> Migraines/Headaches	<input type="checkbox"/> Stomach Problems					
	<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Homesickness	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Thyroid Condition					
	<input type="checkbox"/> Autism/Aspergers	<input type="checkbox"/> Developmental Delays (other)	<input type="checkbox"/> HIV/Aids	<input type="checkbox"/> Seizures	<input type="checkbox"/> Ulcers					
	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Sinus/Colds, frequent	<input type="checkbox"/> Urinary Tract					
	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> IBS	<input type="checkbox"/> Sore Throats	<input type="checkbox"/> Visual Problems					
	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Ear Infections, frequent	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Skin Conditions	<input type="checkbox"/> Other (describe):					

