HeLa Ventures Outdoor Adventure Centre
MEDICAL FORM

This form is to be filled out by the participant/participant's guardian and returned to HeLa Ventures program leader, or to your teacher.

Name of Program/School_____Date of Program _____

Name_____Age_____Gender_____

Home Address _____

City_____Province_____Postal Code _____

Email (parent): _____

Home Phone_____Home Phone _____

Work Phone_____Work Phone _____

Provincial Health Care Number_____and/or Blue Cross_____
and/or Insurance Co. Name and Number_____
Name of Family Doctor_____Phone_____

In an emergency, notify:
1. Name_____Phone (day)_____(night)_____
Address_____Relationship_____
2.Name_____Phone (day)_____(night)_____
Address_____Relationship_____

HEALTH HISTORY

Have you recently been in contact with a communicable disease?_____
If yes, which disease_____and when? _____
Do you have any knowledge of past/present medical conditions of:
Epilepsy_____Convulsions_____Asthma_____
Diabetes_____Skin Disorders_____Heart Conditions_____
Sleep Walking_____Chronic Headaches_____Ear Infections_____
Anxiety_____ Eating Disorder _____
Other_____

Allergies (e.g., specific drugs, certain foods, insect stings, hay fever, animals)
Specify:_____
_____
_____
Reaction to above? _____
_____
_____

Carries Epi Pen? Yes No

Medical/Physical Conditions that may affect participation in the program/activity (e.g., recent illness or injury, chronic conditions, emotional/behavioral state, phobias, etc.) Specify the condition(s) and requirements for program modifications or specific activities your child should not participate in: _____

_____

_____

_____

_____

Medication(s) taken (name, reason, dosage, storage, potential side effects/treatment of such): _____

_____

_____

_____

_____

Medications must be clearly labelled and in original containers with instructions as to the dosages and the time drugs must be administered. Please supply only enough for the days of the program.

Does your child administer his/her meds independently? Yes No

Dietary Concerns: (Please note some special diets require an additional $5.00/day surcharge. Please contact HeLa Ventures for clarification, 403-845-4325.)

_____

_____

_____

_____

Other Health/Medical Concerns we should be aware of:_____

_____

_____

_____

AUTHORIZATION

This health form is correct so far as I know, and the applicant herein described will participate in all camp activities, expect as noted by me. In an Emergency, I hereby give permission to the physician selected by HeLa Ventures to hospitalize, secure proper treatment from, and to order injections, anesthesia or surgery for the applicant named. I agree to pay for charges not covered by my medical plan, i.e. medications, ambulance ride, etc.

Form completed by_____Signature_____

Date_____

Please Return Forms to your Teacher/Group Leader.