Base de Plein Air
Mont-Tremblant
3595, rue Léonard, Mont-Tremblant QC J8E 2A5
Telephone: (819) 425-2461 Fax: (819) 425-7121

MEDICAL FORM

Please return this completed sheet at the *Base de Plein Air* because this information will be needed in case of emergency. Thank you.

General information about the child:

Date of arrival:_____ Date of Departure: _____ Weeks at camp: _____

Has your child already attended a camp? ❒ Yes ❒ No

Camper's Name : _____ Phone number : _____

Address:_____ City:_____ Postal code: _____

Gender: F ❒ M ❒ Date of birth: _____/_____/_____ Age during stay at camp:_____
MM DD YYYY

Camper medicare number: _____ Expiring date: _____

Name of doctor: _____ Phone #: _____ Clinic/hospital: _____

Child's Guardian

Father's name:_____Tel:_____or:_____

Mother's name:_____Tel:_____or:_____

Custody of child: Father and mother ☐ Mother ☐ Father ☐ Shared ☐ Guardian ☐

In case of emergency

Person to contact in case of emergency:

Father and mother ☐ Mother ☐ Father ☐ Shared ☐ Guardian ☐

Other person to contact in case of emergency:

Name:_____ Relationship to child:: _____ Phone# :_____ Work # :_____

Name:_____ Relationship to child:: _____ Phone# :_____ Work # :_____

Name:_____ Relationship to child:: _____ Phone# :_____ Work # :_____

Surgical history

Has your child ever undergone a surgical procedure? Yes ❒ No ❒ If yes:_____

Date _____ Reason _____Results _____

Serious injury:

Date : _____ Describe: _____

Chronic or recurring ailments:

Date : _____ Describe: _____

Medical History

Has the child ever had…		Does the child suffer from…	
Ear infections	Yes ☐ No ☐	Asthma	Yes ☐ No ☐
Mumps	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐
Chicken pox	Yes ☐ No ☐	Epilepsy	Yes ☐ No ☐
Measles	Yes ☐ No ☐	Migraines	Yes ☐ No ☐
Scarlet fever	Yes ☐ No ☐	Hyperactivity	Yes ☐ No ☐
Other, specify:		Other, specify:	

Please add any significant details of these illnesses or ailments:

_____

_____

_____

Girl: Has she begun her menstruations? ☐Yes ☐ No, and she is not informed
☐ No, but she is informed

Are there any particular considerations you feel it important to include?

_____

VACCINATIONS		**DATE**	**ALLERGIES**	
Measles	Yes ☐ No ☐		Hay fever	Yes ☐ No ☐
Rubella	Yes ☐ No ☐		Ragweed	Yes ☐ No ☐
Mumps	Yes ☐ No ☐		Insect stings	Yes ☐ No ☐
DCT	Yes ☐ No ☐		Animals*	Yes ☐ No ☐
Polio	Yes ☐ No ☐		Penicillin	Yes ☐ No ☐
			Other medication*	Yes ☐ No ☐
			Allergy to peanuts	Yes ☐ No ☐
			Food allergy	Yes ☐ No ☐
Other, specify:			Other, specify:	

Does your child carry a dose of adrenaline (Epipen, Ana-Kit) for allergies? Yes ☐ No ☐
If yes, who is authorized to keep and administer this medication, and what is the dosage regimen?

The child ☐ Any responsible adult ☐
The child's counsellor ☐ Dosage: _____

SIGN THIS SECTION IF YOUR CHILD CARRIES A DOSE OF ADRENALINE

I hereby authorize the persons designated by the camp to administer, when needed in case of emergency, the dose of adrenaline _____ to my child.

_____
Parent's signature

MEDICATION

Does your child take any medication?	Yes ☐ No ☐
If yes:	
Medication name	Dose
Is it self-administered? Yes ☐ No ☐	Specify:
Other medical information:	

I also authorize you, if necessary, to give my child this medication:

Acetaminophen (Tylenol) ❒ Initials _____ Antihistamine (Benadryl) ❒ Initials _____

Ibuprofen (Advil) ❒ Initials _____ Other _____ ❒ Initials _____

OTHER

Does your child have behavioural issues?	Yes ☐ No ☐
If yes, describe:	
Does your child wet the bed?	Yes ☐ No ☐
Does your child sleepwalk?	Yes ☐ No ☐
Does your child eat normally?	Yes ☐ No ☐
If no, describe:	
Does your child wear a prosthesis?	Yes ☐ No ☐
If yes, describe:	
Are there any limitations to certain activities?	Yes ☐ No ☐
If yes, describe:	

PARENTAL AUTHORIZATION

Media

Since the Base de Plein Air Mont-Tremblant will photograph and/or film my child during his/her stay at camp, I authorize them to use the material in whole or in part for advertising ends (brochure, website, etc.). All footage and photos will remain property of the Base de Plein Air Mont-Tremblant and/or the Quebec Camp Association.

If your child is required to take medication, on your arrival at camp you must complete the medication permission form or provide us with written authorization so that we may administer the doses prescribed to your child.

- Please note that all information will be kept confidential. Only the information regarding your child's health will be divulged to his counsellor and his/her immediate superior to ensure an appropriate approach and more effective intervention in the event of an emergency.
- In signing this form, I authorize camp management to administer first-aid care to my child. If camp management deems it necessary, I also authorize transportation of my child by ambulance or other means to a hospital or community healthcare establishment.
- I agree to cooperate and to meet with camp managers if my child's behaviour is disruptive to regular camp life.

_____

First and last name of parent or guardian

_____ _____

Parent or guardian signature Date