



Camp Ak-O-Mak

2011

MEDICAL QUESTIONNAIRE

Camp Ak-O-Mak has a full-time infirmary attendant & a physician on call or on site 24 hours a day. Hospitals are 45 minutes away in Parry Sound and Huntsville.

The following medical history / health forms are for our reference as needed. All information provided on the health forms is private and confidential.

Name of Camper: _____

Date of Birth: Day _____ Month _____ Year _____

Parent/Guardian: _____

Home Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

If not available in an emergency, notify:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

INSURANCE:

Insurance Carrier Name: _____ Group No.: _____

Provincial Health Card No. (i.e.: OHIP) _____
& Version Code.

Camp Ak-O-Mak carries a mandatory Student Emergency Medical Insurance policy in Canada providing coverage up to \$100,000. This medical coverage is for non-Canadians & out-of-province campers who must also be students in order to qualify. The cost for non-Canadians is \$4.50 per day & out-of-province Canadians is \$1.00 per day. This cost is in addition to your daughter's tuition and will be add to your invoice, calculated according to the length of her stay upon registering. "Personal Medical Items" (including splints, tensors, slings, wound/dressing materials etc.) and non-OHIP covered items will also be invoiced to the camper's refundable expense account. We strongly suggest all non-Canadians traveling to Camp also purchase Travel Insurance for their stay in Canada.

Parent/Guardian Signature: _____



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MEDICAL HISTORY ~ 1 OF 5

Health History: VERY Important and MUST Be Completed

Camper's Name: _____

ALLERGIES:

MEDICATION ALLERGIES: (LIST ALL)

DESCRIBE REACTION:

1. _____

1. _____

2. _____

2. _____

3. _____

3. _____

FOOD ALLERGIES: (LIST ALL)

DESCRIBE REACTION:

1. _____

1. _____

2. _____

2. _____

3. _____

3. _____

DIETARY RESTRICTIONS:

1. _____ Does not eat red meat

4. _____ Does not eat eggs

2. _____ Does not eat pork

5. _____ Does not eat dairy products

3. _____ Does not eat poultry

6. _____ Does not eat seafood

7. _____ Other (please describe) _____



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MEDICAL HISTORY ~ 2 OF 5

Health History: VERY Important and MUST Be Completed

Camper's Name: _____

Has your daughter ever experienced any of the following (Please Circle)

- | | | |
|---|-----|----|
| 1. A recent injury, illness or infectious disease | YES | NO |
| 2. Chronic or recurring illness / condition | YES | NO |
| 3. Surgery / Hospitalization | YES | NO |
| 4. Seizure disorder | YES | NO |
| 5. Heart Murmur / Heart Problems | YES | NO |
| 6. Asthma | YES | NO |
| 7. Diabetes | YES | NO |
| 8. Bedwetting | YES | NO |
| 10. Frequent ear infections | YES | NO |
| 11. Frequent Headaches | YES | NO |
| 12. Head injury / loss of conscious | YES | NO |
| 13. High Blood Pressure | YES | NO |
| 14. Back problems | YES | NO |
| 15. Joint problems (knees, ankles, shoulders) | YES | NO |
| 16. Menstrual Problems | YES | NO |



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MEDICAL HISTORY ~ 3 OF 5

Health History: VERY Important and MUST Be Completed

Camper's Name: _____

Has your daughter ever experienced any of the following, continued:

- | | | |
|--|-----|----|
| 17. Diarrhea / constipation / digestive problem's | YES | NO |
| 18. Emotional / psychological / attention deficit issues | YES | NO |
| 19. Mononucleosis in the past 12 months | YES | NO |
| 20. Fainting after exercise | YES | NO |
| 21. Does your daughter wear glasses / contact lenses or regular protective eye wear? | YES | NO |
| 22. Skin Problems (rashes, acne, itching etc.) | YES | NO |
| 23. History of eating disorder | YES | NO |
| 24. Cultural or religious reasons for not swimming during menstruation? | YES | NO |

Please explain "Yes" answer, noting the number of the question:

Physical restriction to Activities: Has your daughter sustained an injury that will limit her participation? (What adaptations are necessary?)



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MEDICAL HISTORY ~ 4 OF 5

Health History: VERY Important and MUST Be Completed

Camper's Name: _____

CURRENT MEDICATION:

YES

NONE

1. _____	_____	_____
Medication	Dosage	Frequency
2. _____	_____	_____
Medication	Dosage	Frequency
3. _____	_____	_____
Medication	Dosage	Frequency
4. _____	_____	_____
Medication	Dosage	Frequency

Please identify medication taken during the school year that the camper does not take during the summer. (if any): _____

IMPORTANT:

If your child has any unusual health conditions as listed below please check the box.

Anaphylaxis.

Allergy to Drug(s).

Not to receive certain medical treatments for Religious reasons.

Please Explain: _____



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MEDICAL HISTORY ~ 5 OF 5

Health History: VERY Important and MUST Be Completed

Camper's Name: _____

Has the camper had any of the following illness:

Measles:	<input type="checkbox"/>	Mumps:	<input type="checkbox"/>	Hepatitis B:	<input type="checkbox"/>
Chicken Pox:	<input type="checkbox"/>	Hepatitis A:	<input type="checkbox"/>	Hepatitis C:	<input type="checkbox"/>
German Measles:	<input type="checkbox"/>	H1N1 Influenza:	<input type="checkbox"/>		

Please give dates of last immunization update: Hepatitis B: _____

DTP (Dip. Tet. Pert.): _____ Mumps: _____

TD (Tet/Dip): _____ Rubella: _____

Tetanus: _____ Haemophilus Influenza B: _____

Polio: _____ Varicella (Chicken Pox): _____

MMR: _____ Meningitis Vaccine: _____

Measles: _____ TB Mantoux Test: _____

Result: Positive: _____ Negative: _____

H1N1 Vaccine: _____ Yes _____ No

Date: _____

Parent/Guardians: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the Camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian

Print name of Parent/Guardian