



# Camp AK-O-MAK Non Profit



2025

## MEDICAL HISTORY ~ 1 OF 4

**VERY Important and MUST Be Completed**

Camper's Name: \_\_\_\_\_ Session: \_\_\_\_\_

**CURRENT MEDICATION:** YES  NONE

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

**Drug Allergies:** \_\_\_\_\_

### IMPORTANT:

Please check the box if your child has any of the following.

Anaphylaxis.

Not to receive certain medical treatments for Religious reasons.

**Please Explain:** \_\_\_\_\_

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

**Business Office:** 14-441 Stonehenge Dr., Ancaster, Ontario, Canada L9K 0B1, T: 416.427.3171, F: 905.304.2982

**Email:** [Dianne@campakomak.com](mailto:Dianne@campakomak.com)

**Website:** [www.campakomak.com](http://www.campakomak.com)

**Summer Address:** 240 Akomak Rd, Ahmic Harbour, Ontario, Canada P0A 1A0, T: 705.387.3810, F: 705.387.0077



# Camp AK-O-MAK Non Profit



2025

## MEDICAL HISTORY ~ 2 OF 4

**VERY Important and MUST Be Completed**

Camper's Name: \_\_\_\_\_ Session: \_\_\_\_\_

My child has experienced the following in the past: (Please Circle)

- |                                                                         |     |    |
|-------------------------------------------------------------------------|-----|----|
| 1. A recent injury, illness or infectious disease                       | YES | NO |
| 2. Chronic illness / condition                                          | YES | NO |
| 3. Surgery / Hospitalization past 12 months                             | 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 |
| 9. Frequent ear infections                                              | YES | NO |
| 10. Head injury / Concussion / Headaches                                | YES | NO |
| 11. Musculoskeletal problems ( spine, knees, ankles, shoulders)         | YES | NO |
| 12. Constipation/ diarrhea / digestive problem's                        | YES | NO |
| 13. Attention/Learning challenges / Emotional issues                    | YES | NO |
| 14. Skin Problems (rashes, acne, itching etc.)                          | YES | NO |
| 15. History of eating disorder                                          | YES | NO |
| 16. Cultural or religious reasons for not swimming during menstruation? | YES | NO |



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## MEDICAL HISTORY ~ 3 OF 4

**VERY Important and MUST Be Completed**

Camper's Name: \_\_\_\_\_ Session: \_\_\_\_\_

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

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

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### **DIETARY RESTRICTIONS:**

**Does NOT Eat:** (please check all that apply) (Milk & Dairy only click if allergic)

Red Meat: \_\_\_\_\_ Poultry: \_\_\_\_\_ Eggs: \_\_\_\_\_ Dairy Products: \_\_\_\_\_

Pork: \_\_\_\_\_ Fish: \_\_\_\_\_ Seafood: \_\_\_\_\_ Milk: \_\_\_\_\_

Other (please describe)

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## MEDICAL HISTORY ~ 4 OF 4

**VERY Important and MUST Be Completed**

Camper's Name: \_\_\_\_\_ Session: \_\_\_\_\_

**Please give Year of immunization update:**

Tetanus: \_\_\_\_\_ Flu Shot: \_\_\_\_\_

Measles / Mumps / Rubella: \_\_\_\_\_

Meningitis Vacc: \_\_\_\_\_ Varicella (Chicken Pox): \_\_\_\_\_

I confirm that \_\_\_\_\_'s immunizations are up to date unless otherwise specified above.

IN GENERAL: Any information Social, Emotional, to help us understand your daughter,

Social: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Emotional: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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 health care by the camp physician, to 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 This completed form may be copied for trips out of camp.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Print name of Parent/Guardian

\_\_\_\_\_  
Date:

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