

HEALTH SUMMARY



TO BE COMPLETED BY PARENTS OR GUARDIAN

DATE ARRIVAL AT CAMP: //	Date of departure///////					
FAMILY NAME :	FIRST NAME:					
DATE OF BIRTH: YEAR MONTH DAY	AGE AT CAMP:SEX: F □ M □					
MEDICARE CARD#	EXP DATE: / YEAR MONTH					
FAMILY NAME AND FIRST NAME OF PARENT (S) OR GUARDIAN LIVING WITH THE CHILD:						
TEL: HOME ()CELL ()						
OTHER PERSON TO CONTACT IN CASE OF EMERGENCY						
RELATION:						
Tel: home ()Cell ()EMAIL:					

Does your child suffer from....

FREQUENT COLDS?	YES 🗆	No 🗆	FREQUENT HEAD- ACHES ?	YES 🗆	No 🗆
BEDWETTING?	YES 🗆	No 🗆	EPILEPSY?	YES 🗆	No 🗆
FAINTING?	YES 🗆	No 🗆	SKIN DISEASES?	YES 🗆	No 🗆
DIABETES?	YES 🗆	No 🗆	ASTHMA?	YES 🗆	No 🗆
ADHD	YES 🗆	No 🗆	OTHER NEUROLOGICAL DISORDERS	YES 🗆	No 🗆

DOES YOUR CHILD SUFFER FROM ANY ALLERGIES ?		YES □	No □
DOES YOUR CHILD NEED TO CARRY AN EPIPEN ?		YES □	No
	EDOLEG OD DEGEDJOTIONS	VEC -	No -
DOES YOUR CHILD HAVE ANY FOOD ALL	L ERGIES OR RESTRICTIONS!	YES 🗆	No 🗆
IF YES, PLEASE SPECIFY			
DOES YOUR CHILD HAVE AN INJURY OR ILLN CAMP ACTIVITIES?	IESS THAT COULD AFFECT HER	/HIS PARTICI	PATION IN
		YES □	No □
IF YES, PLEASE SPECIFY:			
DOES YOUR CHILD TAKE MEDICATION?	YES NO		
NAME OF MEDICATION:	Dosage:		
COMMENTS:			
NAME OF MEDICATION:	Dosage:		
COMMENTS:			
NAME OF MEDICATION:	Dosage:		
COMMENTS:			
Limitation of liability: Considering that all possible precautions ar attending the camp, I accept not to persona any complaint(s) against Sun Youth Campdue to sickness, injury or accident which nechild's goods while in Sun Youth's care. To the communicable disease(s) and is physically medical concern(s) or preoccupation(s) requestions of the having my child's medical information others if needed. Through the present, I authorized the state of health or in the case of an emphysician and/or to a hospital chosen by the form are factual and up to date. I agree to remedical service might recommend. All mines the provided gratis. Dental care can only be will be defrayed by the camper or his/her lease.	ally or through another person — Jeunesse au Soleil or its mennight affect my child or for daniche best of my knowledge, my capable of participating in caruiring supervision or medical chation be shared amongst the chorize the camp personnel, whenergency, to bring or to have necessed in the camp. I certify that the information medical treatments as require provided in Montreal and tree	representing nbers and em nage or loss of hild does not np activities. care have been required by child brounation contained by the care to the care t	me , lodge iployees of my have any noted. I mel and y my leght to a ined the limber will
SIGNATURE OF A PARENT OR GUARDIAN	ı:		
DAT	E:		