Camp Selah by Ukrainian Bible Camp Inc.

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Medical Information Form 2020

EMERGENCY CARE INFORMATION

Child's full name: _____

Date of Birth: (dd/mm/yyyy) _____

Name of primary care physician and phone number_____

Child is allergic to the following medications: _____ ☐ None

Child is taking the following medications: _____ ☐ None

Child is diabetic, has other chronic condition or major illness: _____ ☐ None

Does the camper have any allergies? ☐ No ☐ Yes (If yes please describe below)

Please describe: _____

_____

Details: _____

If subject to any of the following, please check (x) and give details (use back of form if needed):

☐Asthma ☐Contact Lenses ☐Headaches ☐Migraines ☐Fainting Spells ☐HIV ☐Ear Problems ☐Diabetes ☐Bleeding ☐Disorders ☐Cramps ☐Convulsions

Other: _____

Does the camper require special care, medication or diet?

Details: _____

Is it currently necessary to restrict the camper's activities for medical reasons? ☐ No ☐ Yes

Health Coverage: Each guest, including non-residents must provide evidence of coverage under Ontario Health Insurance or equivalent. Non-residents will be billed for the costs of hospital out-patient visits [emergency room, X-rays, etc.]. If for any reason my child receives special medication or services beyond that furnished by Camp Selah, I agree to pay for or seek reimbursement from my own insurance company for all such expenses.

Medical Treatment: I hereby give permission to the physician and nurses selected by Camp Selah Directors to assess and give medical treatment, including prescriptions, when necessary to my son/daughter. In the event that a guest requires special medication, transportation, X-ray or treatment beyond that which is possible at the resort, the parents will be charged with the additional expense. In case of surgical emergency, I hereby give permission to the physician selected by the Director of Camp Selah to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child as named above and will be responsible for any additional expense that may result from such services.

☐ I have read and accept all terms and conditions that are described above and all statements made are true to the best of my knowledge

Name of Legal Guardian_____

Signature_____ Date_____