

AFL Kids' Camp 2015
Leader and Junior Counsellor
Personal Health and Information Form
For the AFL/Centre for Outdoor Education/Goldeye

**Please fill in and return to the AFL before July 13th. Fax to 780-484-5928,
scan and e-mail to afl@afl.org or enclose in the attached self-addressed envelope.**

Please print clearly. Read the entire form before completing. This form must be completed by each junior counsellor and leader and signed by parent or guardian if the junior counsellor is under 18 years of age and returned to the AFL before July 13th. If you do not have time to return the form to the AFL, please ensure the form is brought to camp or buses. **This form must be at camp with the Director – no exceptions!**

The information on this form will be treated with confidentiality and used at the discretion of the Camp Director and Nurse to ensure care and attention is given to your health. We would appreciate you giving the following questions your careful attention.

General Information (please print)

Leader/Junior Counsellor's Name: _____

Age: _____ Gender: _____ Birth Date: _____

Height: _____ Weight: _____

Parent/Guardian's Name: _____

Address: _____

City: _____ Postal Code: _____ Phone (day): _____

Phone (night): _____ Cell Phone: _____

E-mail Address: _____

Alberta Health Care #: _____ Subscriber's Name: _____

Blue Cross #: _____ Subscriber's Name: _____

Other Insurance: _____

Family Doctor: _____

Address: _____

Doctor's Phone: _____

Emergency Contacts (please provide two contacts)

1. Name: _____ Relationship: _____
Home #: _____ Work/Cell #: _____
2. Name: _____ Relationship: _____
Home #: _____ Work/Cell #: _____

Medical History

The camp program will include hiking, swimming, boating, rappelling, games, etc. If you suffer from any physical or emotional disorder that would prevent you from participating fully in the camp program, please state particulars:

Please provide any special instructions for staff regarding your health care:

Please provide a list of allergic reactions to drugs, food, insect stings, etc. and list the type of reaction and treatment.

For each allergy, please indicate contact or ingestion.

Allergy/Treatment

Contact (C) or Ingestion (I) Allergy

_____	_____
_____	_____
_____	_____

Are you allergic to bee stings? _____ If yes, do you carry medicine? _____

Name of medicine: _____ Nature of reaction: _____

Dietary restrictions: _____

Date of last tetanus shot: _____ Corrective lenses required? _____

Chronic conditions or recent illness which the staff should be aware of:

List all medications you will be bringing to camp, include dosage and purpose of medication (**all medication, including non-prescription drugs, must clearly display your name, the type of medication, the dosage and frequency. It will be stored and dispensed by the camp director or designate**):

Any other comments about your health:

Name any illness or condition for which you are now undergoing treatment and list any medications that you are currently taking:

If you have had any of the following conditions, state the year of occurrence and the body location in which it occurred:

Hernia _____ Fracture _____

Dislocation _____ Sprain or Strain _____

Name any injury, illness, or disability not mentioned, and year of occurrence:

If you have or has had any of the following symptoms or conditions, circle "Yes," ***underline specifics***, and provide sufficient details. If not, circle "No."

- | | | |
|---|-----|----|
| (a) Is he/she a transplant recipient? | Yes | No |
| (b) Cardiac disease/condition | Yes | No |
| (c) Active orthopaedic problem | Yes | No |
| (d) Atlantoaxial Instability (AAI) | Yes | No |
| (e) Abdominal organ enlargement | Yes | No |
| (f) Does your child have any medical condition for which your doctor has advised you to limit the physical activity you do? | Yes | No |

(*Please note that any information provided to us about your medical conditions will be kept entirely confidential. Your group will not know what you have revealed. However, it is very important that you advise us of any of the above conditions because participating in the Challenge Course can have adverse and potentially severe consequences for these conditions.)

Provide any details in regard to any questions to which you have circled "Yes":

Leader or Junior Counsellor's Signature: _____

Junior Counsellors under 18: Name: _____

Age: _____ **Birth Date:** _____

Parent/Guardian's Name: _____

Parent/Guardian's Address (if different from above): _____

If you are under 18 and have any medications that you will be bringing with you, please list. All medication (including non-prescription drugs) must clearly display your name, the type of medication, the dosage and frequency. It will be stored and dispensed by the camp director or designate.

Parent/Guardian's Signature: _____

Junior Counsellor's Signature: _____