**Rotary Club of Peterborough Kawartha**

**Adventure In Understanding – 2020 Canoe Experience Health Form**

**August 30, 2020 to September 04, 2020**

**CAMPER INFORMATION: (print clearly)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last Name: | |  | | | | | | First Name: | | | |  | | | | | | | | Middle Initial: | | | |  |
| Birthdate (yyyy/mm/dd): | | | | | |  | | | Camper’s Age on Aug 1, 2020: | | | | | | |  | | | Gender: | | | | ❑ Male ❑ Female | |
| Home Address: | | | | |  | | | | | | | | | | | | | | | | | | | |
| City/Town: | | |  | | | | | | | Province/State: | | | |  | | | Postal Code: | | | | |  | | |
| Home Phone: | | | |  | | | Cell Phone: | | | |  | | | | | | | Other: | | |  | | | |
| Email # 1: |  | | | | | | | | | | | | Email # 2: | |  | | | | | | | | | |

**PARENTS/GUARDIANS & EMERGENCY CONTACTS****: (print clearly)**

**Marital Status of Camper’s Parents/Guardians**:

❑ Single ❑ Married ❑ Separated ❑ Widowed ❑ Divorced ❑Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal Custody** (be sure to include their contact information below):

❑Both Parents (live together) ❑Joint Custody (live apart) ❑Mother ❑Father ❑ Grandparents ❑Guardian ❑Foster Parents

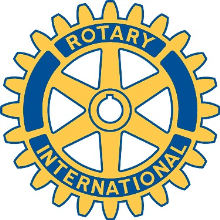
**Emergency Contact*:***

Please list in order who should be contacted in case of emergency – be sure to include parents/guardians

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1st Contact: ❑Mr. ❑Mrs. ❑Ms. ❑Miss ❑Dr. | | | 2nd Contact: ❑Mr. ❑Mrs. ❑Ms. ❑Miss ❑Dr. | | |
| First & Last Name: | |  | First & Last Name: | |  |
| Relationship: |  | | Relationship: |  | |
| Home Phone: |  | | Home Phone: |  | |
| Work Phone: |  | | Work Phone: |  | |
| Cell Phone: |  | | Cell Phone: |  | |
| Address: |  | | Address: |  | |
| City: |  | | City: |  | |
| Prov & PC: |  | | Prov & PC: |  | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 3rd Contact: ❑Mr. ❑Mrs. ❑Ms. ❑Miss ❑Dr. | | | 4th Contact: ❑Mr. ❑Mrs. ❑Ms. ❑Miss ❑Dr. | | |
| First & Last Name: | |  | First & Last Name: | |  |
| Relationship: |  | | Relationship: |  | |
| Home Phone: |  | | Home Phone: |  | |
| Work Phone: |  | | Work Phone: |  | |
| Cell Phone: |  | | Cell Phone: |  | |
| Address: |  | | Address: |  | |
| City: |  | | City: |  | |
| Prov & PC: |  | | Prov & PC: |  | |

**MORE INFORMATION ON PAGE 2 PAGE 1**



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**HEALTH INFORMATION**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Campers Health Card #:** | | | |  | | | | | | | | **Version Code:** | | | |  | | | *A photo for emergency purposes will be taken on arrival day.* |
| Family Doctor: |  | | | | | | | | Phone: | | |  | | | | | | |
| Address: | |  | | | | | | | | | City: | |  | | | | | |
| Permission for attending Doctor/Nurse to contact your Family Doctor if necessary? | | | | | | | | | | | | | | Yes ❑ No ❑ | | | | |
| **Immunization Dates:** | | | Tetanus: | |  | | Polio: |  | | | | | | | Pertussis: | |  | | |
| (dd/mmm/yyyy) | | | Diphtheria: | | |  | Hepatitis B: | | |  | | | | | Meningitis: | | |  | |

**DIETARY RESTRICTIONS:** ❑ Vegetarian ❑ Vegan ❑ Lactose Intolerant ❑ Gluten Free ❑ Other:

**ALLERGIES:** Be Specific, attach a separate page if necessary. If participant uses an Epipen, they must bring it on the trip. If you child has a life threatening allergy, you MUST fill out an “ANAPHLAXIS EMERGENCY PLAN FORM” in addition to this health form.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Indicate Type: Drug, Food, Environmental, Insect, Other | Allergen  (please be specific) | Type & Severity of Reaction  (Indicate if life-threatening) | Management / Treatment / Medication | Date of Last Reaction |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**ASTHMA:** Does your child suffer from asthma? ❑ Yes ❑ No If yes, indicate severity? ❑ Mild ❑ Moderate ❑ Severe

What are the triggers for these attacks?

**MEDICATIONS:** Is the participant on any medication (prescription or homeopathic/naturopathic)? ❑ Yes ❑ No If yes, please list:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Amount | Frequency | Other Relevant Information |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Please list any extra or relevant health information below:

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