CANUCKS AUTISM NETWORK

2019 Overnight Camp Medical Form

A Medical Physician MUST *complete and sign this form during appointment with participant*
**** PLEASE PRINT ALL INFORMATION LEGIBLY****

Participant's Name (First and Last):_____
BC Care Card Number:_____
Date of Birth:_____
Age:_____ Gender:_____Height:_____Weight(LBS):_____

Are this individuals immunizations up to date? (Circle one) YES/NO **For our records only**

Does this participant require an EPI PEN ? (Circle one) YES/NO If yes please specify, *parent/ guardian will also include details in the online camp participation information form:*

_____
_____
_____

Special Medical Considerations:
Are there any precautions or limitations to physical activity that this participant should observe? (Circle one) YES/NO If yes please specify:

_____
_____
_____

Has this individual experienced any seizures within the las 12months? (Circle one) YES/NO If yes please specify *If yes parent/guardian to include details in the online camp participation information form*

_____
_____
_____

Has this individual been exposed to or does he/she presently have a concerning communicable illness or disease (including but not limited to Hepatitis, Tuberculosis, HIV) ? (Circle one) YES/NO If yes please specify:

_____
_____

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Participant's Name (First and Last):_____

MEDICATIONS

Please list all prescription medications that will be accompanying the individual to camp including PRN's (ie. Inhalers, ointments, pain medication). ***Only items listed can be delivered by the Camp Health Care Team. If there is a change in medication between now and the start of camp you can print off the updated medication form, have a doctor sign it and bring with you to camp drop off. The Nurse will review with parent/guardian.***

Generic Name	Dosage (MG)	Quantity (ii/mls)	Routine Time Administered

If you require additional space to list medications please print off a second copy of this form.

All prescription Medication must be in it's original package, including Participant's first and last name, pharmacy name and telephone number, Doctor's name ,, name of medication, dosage and time of administration OR you can ask your pharmacy to create a Blister Pack.

Medical Practitioner's Name: _____ Phone Number: _____
(Please Print)

Medical Practitioner's Signature: _____Date: _____

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Participant's Name (First and Last):_____

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