CANUCKS AUTISM NETWORK

2022 Overnight Camp Medical Form

A Medical Physician MUST *complete and sign this form during an appointment with the participant*

**** PLEASE PRINT ALL INFORMATION LEGIBLY****

Participant's Name (First and Last):_____

BC Care Card Number:_____

Date of Birth (MM/DD/YYYY):_____

Age:_____ **Gender:**_____ **Height:**_____ **Weight (LBS):**_____

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

Does this participant require an EPI PEN? **YES/NO** (Circle one) If yes, please specify:*

_____

_____

Special Medical Considerations:

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

_____

_____

Has this individual experienced any seizures within the last 12 months? **YES/NO** (Circle one) If yes, please specify:*

_____

_____

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

_____

_____

Are there any mental health concerns CAN staff should be aware of? **YES/NO** (Circle one) If yes please specify*:

_____

_____

**Parent/guardian to include details in the online 'Overnight Camp Participant Form'*

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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 (i.e. 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, get it signed by a doctor, and bring with you to camp drop off where the Camp Nurse will review the updated details with the 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** labelled with: the participant's first and last name, pharmacy name and telephone number, doctor's name, name of medication, dosage and time of administration.

You may also consider asking your pharmacy to create a Blister Pack.

Medical Practitioner's Name: _____ **Phone Number:** _____

(Please Print)