

The Beat - 2012 Health Form

655 Parkhill Rd W Unit 6, Peterborough, Ontario, Canada, K9J 6N7
Phone: 705-872-2630 Email: info@thebeatcamp.ca

HEALTH INFORMATION

Dancers' Name: _____

PLEASE FILL OUT THIS FORM PRIOR TO ARRIVAL.

Dancers Health Card #: _____ Version Code: _____

Family Doctor: _____ Phone: _____ City: _____

Dietary Information:

Vegetarian Vegan Lactose Intolerants Other

Allergies: Be specific, attach separate page if necessary. If dancer uses an epipen, they must bring it to camp.

Indicate Type, Drug, Good, Environmental, Insect, Other

Allergen: Type and Severity of Reaction (Indicate if life-threatening)

Management/Treatment/Medication

Date of Last Reaction

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?

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Medications:

Is dancer currently on any medication (prescription or homeopathic) If so, what?

How and when is this medication administered?

Over the Counter Medicine:

Check if you approve the use of the following over the counter medicine that the camp has for your child. If deemed necessary.

Tylenol:	<input type="checkbox"/>	Cough medicine:	<input type="checkbox"/>	Gravol:	<input type="checkbox"/>
Advil:	<input type="checkbox"/>	Cold medications:	<input type="checkbox"/>	Antihistamines:	<input type="checkbox"/>

If no, what would be an appropriate alternative?

The Beat dance camp will require dancers to actively participate in dance workshops and related activities. Does your child have any physical, developmental, behavioral, or emotional conditions that may affect his/her ability to participate in camp activities? Yes / No . If yes, give details:

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Health History check if camper has had, or is subject to any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> heart conditions | <input type="checkbox"/> eye trouble |
| <input type="checkbox"/> measles | <input type="checkbox"/> mononucleosis | <input type="checkbox"/> nosebleeds |
| <input type="checkbox"/> mumps | <input type="checkbox"/> frequent stomach aches | <input type="checkbox"/> toothaches |
| <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> frequent headaches | <input type="checkbox"/> frequent colds |
| <input type="checkbox"/> whooping cough | <input type="checkbox"/> migraines | <input type="checkbox"/> sinus trouble |
| <input type="checkbox"/> hepatitis | <input type="checkbox"/> sprains or strains | <input type="checkbox"/> bedwetting |
| <input type="checkbox"/> epilepsy/seizures | <input type="checkbox"/> fractures | <input type="checkbox"/> nightmares |
| <input type="checkbox"/> fainting/dizziness | <input type="checkbox"/> ADD/ <input type="checkbox"/> ADHD | <input type="checkbox"/> sleepwalking |
| <input type="checkbox"/> appendicitis | <input type="checkbox"/> ear trouble | <input type="checkbox"/> other |
| <input type="checkbox"/> tonsillitis | | |

If your child has or had any of the above, please give details. Does it affect their ability to participate in activities? Yes / No . If so, how?

Recent hospitalization, operation, injury, serious illness, or infectious disease: If so, give date and details:

Do you have any medical concerns regarding your child?

Any other Medical History or information that may be required.

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Important Reminders and Parent/Guardian Signature

Medications must be left with the camp staff while at camp. All prescription medications must be in their original container and must be labeled with the doctor's name, child's name, dosage, schedule, route and date. All over the counter medications must be in the original container with proper labeling.

To the best of my knowledge my child is in good health. I will notify the camp if there is any change in my child's health, or he/she is exposed to any communicable disease within 3 weeks prior to arrival at camp.

In the case of medical emergency, I understand every effort will be made to contact parents or guardians. In the event I cannot be reached, I hereby give permission to the physician/nurse selected by the camp to hospitalize, secure proper treatment, order injection, anesthesia or surgery for my child as named above.

I agree to reimburse the camp for any prescriptions or medical expenses incurred for the camper

I will submit any changes to this health form in writing to the camp prior to arrival.

Parent/Guardian Signature

Date:
