



SCHOOL/GROUP/Camp: _____ Program Date: _____

PARTICIPANT INFORMATION

Name:	Age:	Date of Birth (m/d/y):	Gender:
Address (street/city/province/postal code):			
BC Care Card #		Other Health Insurance:	

Parent/Guardian:	Emergency Contact:
Email:	Relationship:
Phone:	Phone:
Alternate Phone:	Alternate Phone:

FOOD ALLERGIES	Reaction (Bring two epi pens if required)	Epi Pen required?	
		Yes	No
		Yes	No
		Yes	No
		Yes	No

FOOD RESTRICTIONS (please select)

- | | | |
|--|-------------------------|--|
| Gluten Free | No Red Meat | Lacto ovo vegetarian (eggs & dairy ok) |
| Celiac Disease | Lactose Intolerant | Lacto vegetarian (dairy ok) |
| No Pork | Small amount lactose OK | Pescatarian (fish, eggs & dairy ok) |
| Other (use additional page if necessary) | Vegan | |

ALLERGIES (environmental or medications) Reaction Treatment (bring 2 epi pens if required)

ALLERGIES (environmental or medications)	Reaction	Treatment (bring 2 epi pens if required)

HEALTH INFORMATION Please attach a separate sheet or care plan if necessary

- | | | | | |
|---------------------------------------|----------|-------------------|-------------------------------------|--------------------|
| Glasses/Contacts | Diabetes | Recent Concussion | Recent Injury (describe below) | Bedwetting |
| Hearing Aid | ADHD | Seizure Disorder | Frequent Infection (describe below) | Asthma |
| Heart Condition | Autism | Migraine Headache | Anxiety/Phobia (describe below) | H/L blood pressure |
| Other significant health information: | | | | |

PRESCRIBED MEDICATIONS (Please list medical name, what it is used for, dosage, time given)

TETANUS SHOT IMPORTANT INFORMATION. Children in BC receive a tetanus booster in Kindergarten and Grade 9.

Date of last Tetanus shot: _____

CAMPING COMFORT LEVEL Please number from 1-5 (1= very uncomfortable, 5 = very comfortable)

Sleeping in tent Using outhouse Being in dark Extended Exercise

SWIMMING ABILITY Able to swim 100m Able to swim 25m Non-Swimmer

Non-swimmers: are you comfortable in deep water while wearing a life jacket? Yes No

CONSENT TO MEDICAL TREATMENT In the event of a medical emergency, if I am not immediately contactable, I give my consent to treatment to the health care providers (doctors, hospital medical staff, first aid attendants) chosen by the directors of Island Escapades Ltd., to provide whatever treatment is medically necessary for the participant.

I have completed this medical form accurately, truthfully, and to the best of my knowledge as of today's date.

Signature of adult participant/guardian for youth

Today's Date (m/d/y)

Type your full name for digital signature