



# Staff Medical Record

Name: \_\_\_\_\_ Age at Camp: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Prov.: \_\_\_\_\_  
 Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Date of Birth: M \_\_\_\_\_ D \_\_\_\_\_ Yr \_\_\_\_\_ Sex: \_\_\_\_\_  
 Health Card #: \_\_\_\_\_  
 Effective date: \_\_\_\_\_ Expiry Date: \_\_\_\_\_  
**Parent/Guardian Name(s):** \_\_\_\_\_  
 Phone: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_  
**Alternate Emergency Contact (other than parent/guardian):**  
 Name(s): \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

• **Immunizations:**  
 Last Tetanus (Td): \_\_\_\_\_  
 • **Recent exposure to tuberculosis?**  
 Yes  No  
*If yes, please explain treatment on an attached page.*  
 • **Allergies: to foods, environment or medications:**  
 Yes  No  
*If yes, please list and explain.*  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Medications:**  
 Will you be taking any medications while at IAWAH? If yes, please list medications, dose, frequency, and reason for taking. **NOTE:** all medications must arrive at Camp in original containers, clearly labelled by manufacturer or pharmacist.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

• **Please list any special dietary requirements:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Can you be given Tylenol/Ibuprofen if needed?  Yes  No  
 Have you ever been given a local or general anaesthetic?  Yes  No  
 Do you or your family have any reactions to local or general anaesthetic?  
 Yes  No If yes, please explain on the back of this form.

• **Please explain any activity restrictions:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Special Medical Conditions:** Please be thorough in your explanations of any physical, emotional, psychological, or social conditions that the staff member might have. The staff member may be at a disadvantage if explanations are not complete. Information is used only on a need-to-know basis by the directorial, medical, and counselling staff. Please list any such conditions on the back of this form.

**Please attach a letter from your physician explaining any serious medical or allergic conditions.**

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Consent to Treatment**

- I hereby consent to non-emergent treatment of myself/my child while at IAWAH by the medical personnel designated by IAWAH as per physician's standing orders.
- In the event that a staff member requires special medication, x-ray or treatment, beyond that which is possible at Camp, the family will be notified and may be charged with the additional expense of transportation and special care. In the event that the family cannot be contacted, the alternate emergency contact will be notified.
- In case of surgical or medical emergency and if I am not immediately available for consultation, I hereby give permission to the physician selected by Camp to secure proper treatment for myself/my son or daughter as named above. I understand that this may or may not include hospitalization, injections, IV therapy, anesthesia, or surgery.
- Every precaution is taken for the safety and good health of staff members but in the event of accident or sickness, Camp IAWAH (known corporately as Christian Youth Centre [Kingston]) including the Camp Directors and their staff are hereby released from any liability. Each staff member must be covered by Ontario Health Insurance or equivalent medical insurance.
- To the best of my knowledge I am/my child is currently in good health. If this changes, or I am/they are exposed to any contagious diseases within 4 weeks of Camp, I will inform the IAWAH office prior to arrival.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (If staff member is under the age of 18, must be signed by parent/guardian)