CAMPION SCHOOL

Please use this form to report your child's health to the school which is required from the Ministry of Education. Have a licensed medical professional complete part 4-5.

Without this paper and immunization paper your child cannot attend the Summer Camp.

Part 1: Child Personal Information | To be completed by parent/guardian.

Child's Last Name:	**Date of Birth:**	**School Year:**
Child's First Name:	**Gender:** ❑ Male ❑ Female	
Home Address:	**Home Phone:**	**Email:**
Parent's Surname:	**Parent's Name:**	**Parent's Phone:**
Parent's Surname:	**Parent's Name:**	**Parent's Phone:**
Emergency Contact 1 Name:	**Emergency Contact 1 Phone:**	
Emergency Contact 2 Name:	**Emergency Contact 2 Phone:**	

I give permission to the signing health examiner/facility to share the health information on this form with my child's summer camp.

I understand that this form should be completed and returned to my child's summer camp.

Parent's/Guardian's Signature:___________________________________ **Date:** _________________

Part 2: Child's Health History, Exam, and Recommendations | To be completed by parent/guardian.

Does the child have any of the following health concerns? *(Check all that apply and provide details below)*

- ❑ Allergies
- ❑ Asthma
- ❑ Diabetes
- ❑ Heart Problem
- ❑ Seizures
- ❑ Surgical Procedures
- ❑ Vision/wear glasses
- ❑ Autism
- ❑ Behavioral
- ❑ Development
- ❑ Language/Speech
- ❑ Obesity
- ❑ Premature
- ❑ Failure to thrive
- ❑ Emotional concerns
- ❑ Hearing difficulties
- ❑ Long-term medications, over-the-counter-drugs (OTC) or special care requirements.
- ❑ Significant health history, condition, communicable illness, or restrictions.
- ❑ **Other:**____

Provide details.

If the child is currently undergoing medical treatment or has been referred for treatment, please attach a complete Medication/Medical Treatment Plan form:

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CAMPION SCHOOL

Part 3: Parental Consent (at the school's discretion) give permission for my child to be given: | To be completed by parent/guardian.	
❑ Paracetamol ❑ Ibuprofen ❑ Antihistamines ❑ Throat Lozenges (Strepcils)	**In the event that I or my emergency contacts cannot be reached, I give my permission for the school to proceed with emergency medical treatment, if required.** ❑ Yes ❑ No

Part 4: Immunization Information | To be completed by licensed health care provider.	
Immunizations	**Please provide in a copy of Immunization (MM/DD/YY)**
❑ The child is **up to date on immunizations** and a copy will be submitted from the parents/guardians. ❑ The child has not been vaccinated.	

Part 5: Licensed Health Practitioner's Certifications | To be completed by a licensed health care provider.		
This child has been appropriately examined and health history reviewed and recorded in accordance with the items specified on this form. At the time of the exam, this child is **in satisfactory health** to participate in all school, sports activities, tournaments, trips or child care activities. If no, please explain what he/she can and cannot do. ____ ____	❑ No	❑ Yes
This child is cleared for **competitive sports.**	❑ No ❑ Yes	
I hereby certify that I examined this child and the information recorded here was determined as a result of the examination.		

Licensed Health Care Provider Office Stamp	**Provider Name:**
	Provider Phone:
	Provider Signature:
	Date: