NIIGAN MOSEWAK WALKING FORWARD

HEALTH HISTORY

O.P.P.

GENERAL INFORMATION

Name:

Home Address:

STREET CITY/COMMUNITY POSTAL CODE

Phone: Birth date: / / Age:

DAY MONTH YEAR

☐ Female ☐ Male ☐ Other _____ Health Card Number:

Family Physician's Name: Phone:

EMERGENCY CONTACT

Parent/Guardian Name: Relationship to Participant:

Home Address:

STREET CITY/COMMUNITY POSTAL CODE

Phone (day): Phone (night): Email:

Emergency Contact 2: Relationship to Participant:

Phone (day): Phone (night): Email:

HEALTH HISTORY

Height: Weight: Do you wear glasses? ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No If yes, please explain:

Do you have any recent injuries, illnesses or operations? ☐ Yes ☐ No If yes, please explain:

Do you have any diabetes, seizures or frequent fainting/dizziness? ☐ Yes ☐ No If yes, please explain:

Do you have any back, neck or spine injury/pain? ☐ Yes ☐ No If yes, please explain:

PLEASE FILL THIS FORM OUT TO THE BEST OF YOUR ABILITY. THE MORE INFORMATION WE HAVE ABOUT THE CHILD THE MORE PREPARED WE WILL BE TO PROVIDE A MEMORABLE EXPERIENCE.

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Do you have migraines or suffer from headaches? ☐ Yes ☐ No If yes, please explain:

Do you have a history of heart problems? ☐ Yes ☐ No If yes, please explain:

Parents/Guardians: Please use the back of this form to provide a full explanation to anything as it pertains to your child.

If any pertain to your child please check off and explain:

☐ Chicken Pox	☐ Hepatitis	☐ Hay Fever	☐ Homesickness	☐ Motion Sickness
☐ Ear Trouble	☐ Diabetes	☐ Seizures	☐ Nose Bleeds	☐ Sleep Walking
☐ Bed Wetting	☐ Head Lice	☐ Asthma	☐ Heart Condition	☐ Allergies

Does your child have any allergies to?

☐ Medication If yes, please explain:

☐ Food If yes, please explain:

Is your child is allergic to peanuts or peanut products? ☐ Yes ☐ No

Does your child have ADD/ADHD? ☐ Yes ☐ No

If yes, is he/she receiving medication? ☐ Yes ☐ No

If yes, please indicate what medication your child is on and ensure they bring it to camp with a dispensing schedule:

Does your child have any emotional difficulties/disorders? ☐ Yes ☐ No If yes, please explain:

Does your child have any physical limitations or restrictions? ☐ Yes ☐ No If yes, please explain:

Please indicate any other health information we should know to provide you with a safe experience such as special diet requirements, physical activity restrictions, etc.

I certify that the information provided above is a complete and accurate statement:

Participants Signature: Date:

Parent/Guardian Signature: Date:
(IF UNDER 18 YEARS OF AGE)