

MEDICAL FORM

Name:			School/Group:
Age:	Date of Birth:	Gender:	Program Date:
Address:			
Provincial Care Card #:		Other Health Insurance:	
Parent/Guardian:		Emergency Contact:	
Email:		Relationship:	
Phone:		Phone:	
Alternate phone:		Alternate phone:	

DIETARY INFORMATION

Cheakamus Centre is a nut restricted facility. We do not order, import or permit any products containing nuts on site. We cannot, however, fully guarantee that private individuals are not bringing items containing nut products on site for personal consumption or use.

Food Allergy	Reaction <i>*Please bring Epi Pen if required for anaphylactic reactions.</i>	Epi Pen Required?		Trace amount OK?		Baking OK?	
		Yes	No	Yes	No	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Food Restrictions:

- | | | |
|--|---|--|
| <input type="checkbox"/> Gluten Free | <input type="checkbox"/> No Pork | <input type="checkbox"/> Pescetarian (fish, eggs & dairy OK) |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> No Red Meat | <input type="checkbox"/> Lacto Vegetarian (dairy OK) |
| <input type="checkbox"/> Vegan | <input type="checkbox"/> Lacto-ovo-vegetarian (eggs & dairy OK) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> No Dairy → | <input type="checkbox"/> Small Amounts OK | <input type="checkbox"/> Baking OK |
| | <input type="checkbox"/> Ice Cream OK | <input type="checkbox"/> Cheese OK |

IMPORTANT: For highly restrictive diets, parents may be required to supply food supplements. In this event, please contact our kitchen staff at kitchen@cheakamuscentre.ca to review our supplementary food protocols.

HEALTH INFORMATION

Include details in notes section below or attach a separate sheet if necessary. Children with diabetes or other significant medical conditions are required to attach a detailed care plan.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Frequent Infection | <input type="checkbox"/> Anxiety/Phobia |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Recent Concussion | <input type="checkbox"/> ADHD | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Migraine Headache | <input type="checkbox"/> Autism | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Recent Injury | | |

Notes: _____

Allergies (Environmental or Medications)	Reaction	Treatment

Prescribed Medication: Please list all medications the participant will be taking while at Cheakamus Centre.

LIST: what it is used for, dosage, how it is to be given, and times given. Ensure medications are clearly labelled with this information.

(attach separate sheet if necessary)

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 management of Cheakamus Centre, in consultation with visiting teachers, 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 dates.

Signature of adult participant OR custodial parent/guardian for children

Date (M/D/Y)