



Camp Kinkora

Community for Life.

Camper Registration & Medical Form

Year: _____

Summer Session:				
<input type="checkbox"/> Diocesan Liturgy Camp	<input type="checkbox"/> Diocesan Family Camp	<input type="checkbox"/> Foundation Family Camp		
<input type="checkbox"/> Visions Camp	<input type="checkbox"/> Youth in Action Camp	Other: _____		
Camper Information				
Name: _____				
Address: _____				
City: _____		Province: _____		Postal Code: _____
Phone: _____			Camper's Email: _____	
Birthdate ____/____/____/ Age on July 1: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F <small>DD MM YYYY</small>				
Parents / Guardian & Emergency Contacts				
Legal Custody: Who has Custody and is Legally Responsible for this camper:				
<input type="checkbox"/> Both Parents (live together), <input type="checkbox"/> Joint Custody (live apart), <input type="checkbox"/> Mother, <input type="checkbox"/> Father, <input type="checkbox"/> Grandparents, <input type="checkbox"/> Guardian, <input type="checkbox"/> Foster Parents, <input type="checkbox"/> Other _____				
List in order who should be contacted in case of emergency				
1st Contact		2nd Contact		
Name: _____		Name: _____		
Relationship: _____		Relationship: _____		
Home Phone: _____		Home Phone: _____		
Work Phone: _____		Work Phone: _____		
Cell: _____		Cell: _____		
Email: _____		Email: _____		
Important: This medical form must be submitted to our camp office upon registration. Updates can be submitted later by email. Please ensure it is filled out completely & accurately. Campers cannot attend camp without a current medical form on file prior to camp.				
Camper's Health Card# _____		Expiry Date: _____		
Family Doctor: _____		Phone: _____		
Dentist / Orthodontist: _____		Phone: _____		
Immunization Year: Chicken Pox: _____		Hepatitis B: _____		Meningitis: _____
Diphtheria/Pertusis/Tetanus/Polio: _____		Measles/Mumps/Rubella: _____		
Allergies: Does your child have any allergies?				
Indicate Type: Drug, Food, Environmental, Insect, Other	Allergen (please be specific)	Type & Severity of Reaction (Indicate if life threatening)	Management / Treatment / Medication	Date of Last Reaction
EpiPen: Does your child require an EpiPen? <input type="checkbox"/> No <input type="checkbox"/> Yes If your child is required to carry an EpiPen (i.e. bee/wasp allergy), please provide two non-expired EpiPens; one for your child to carry with them and one to keep in the camp infirmary.				
Dietary Restrictions: <input type="checkbox"/> Vegetarian <input type="checkbox"/> Vegan, <input type="checkbox"/> Lactose Intolerant <input type="checkbox"/> Gluten Free Other _____				

Asthma / Inhaler: Does your child have asthma? Yes, No.
 If yes, indicate severity? Mild, Moderate, Severe, Made worse by activity.
 What are the triggers for these attacks? _____
 Will your child be carrying an inhaler Yes No
 If your child will be carrying an inhaler with them, please bring an extra non-expired inhaler to be left in the Infirmery. If your child has used an inhaler in the last year, they are required to have an inhaler at camp.

Medications at Camp: Will your child be taking any medications while at camp (prescription or homeopathic)? If yes, list medication, dosage, schedule, and reason for medication.

Medication	Dosage	Schedule	Reason

All Prescription And Over-The-Counter Medications Will Be Collected And Kept With The Health Care Staff While At Camp. Please be sure that medications are in their original packaging and labeled with the doctor's name, child's name, dosage, schedule, and date. A pharmacy issued blister pack is required if your child requires 3 or more daily medications. Any over-the-counter medications must be in the original packaging.

Treatments: Will your child require any treatments while at camp? If yes, please explain: _____

Over-The-Counter Medicine At Camp: May the following over-the-counter medications be given to your child while at camp, if deemed necessary by the health care staff?

Acetaminophen (Tylenol), Antacids, Antihistamines (Benadryl), Gravol, Ibuprofen (Advil)
 Is there anything the camp needs to be aware of when giving any of the approved over-the-counter medications to your child? _____

Health History: Please check any of the following conditions that your child has or is currently experiencing.

- | | | |
|---|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nightmares / Terrors |
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Ear Infections / Hearing Problems | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Back / Neck Pain or Injury | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Sinus infections |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Fetal Alcohol Syndrome | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Behavioral Issues | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Blackouts / Fainting | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hernia | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Homesickness | <input type="checkbox"/> Sprains, Strains, Fractures |
| <input type="checkbox"/> Chrons / Colitis / IBS | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Constipation / Diarrhea | <input type="checkbox"/> Menstrual Difficulties | <input type="checkbox"/> Visual Problems _____ |
| <input type="checkbox"/> Dental Braces / Caps / Bridges | <input type="checkbox"/> Mental Health Issues | <input type="checkbox"/> Weight / Eating Disorder |
| <input type="checkbox"/> Developmental Delays | <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Other, _____ |

Please provide details about any conditions your child is currently experiencing. Please include all information regarding your child's history of illness so that our health care staff can be prepared in case of incident or emergency. _____

Operations / Hospitalization / Serious Injury: Has your child had any operations, ever been hospitalized, or had a serious injury that may impact their participation in camp activities. If yes, please explain giving details, date of occurrence, any lingering effects on child's health, and any signs of illness that camp staff should look out for.

Date of Occurrence	Lingering Effects	Signs of Illness

Diseases: Has your child had any of the following diseases?

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Mumps	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Whooping Cough

Activity Restrictions: Camp Kinkora is located on a rugged, wooded site. Most of the activities take place outdoors. Does your child have any restrictions on activity? No, Yes If yes, please explain:

Additional Information: Please list any other medical information the camp should know about your child.

Is there anything you would like to discuss with the camp medical staff? _____

IMPORTANT REMINDERS - please read carefully!

- I understand that all information collected will be used to diagnose, treat or maintain my child's physical or mental health and to assist in preventing disease or injury or to promote health. This information is considered to be confidential and will be shared amongst health care providers as needed; ie: Health Care Staff, Camp Nurse, Nurse's Assistant, Walk in Clinic or Emergency Health Care Providers. This information will only be shared with the Camp Director and Camp staff on a need to know basis to ensure the physical and mental health of my child.
- To the best of my knowledge, my child is in good health. I will notify the camp in writing prior to arrival if there is any change in my child's health, or he/she is exposed to any communicable disease within 3 weeks prior to arrival at camp.
- In the case of a medical emergency, I understand that every effort will be made to contact parents or guardians. In the event I cannot be reached, I hereby give permission to the physician/nurse selected by the Camp Director to hospitalize, secure proper treatment, order injection, anesthesia or surgery for my child as named above.
- I agree to reimburse the camp for any prescriptions or medical expenses incurred for this camper.

_____ Parent / Guardian Signature	_____ Date
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Photo Consent

Camp Kinkora will take pictures and/or film various activities involving my child during his/her stay at camp, I hereby authorize the use of this material, in whole or in part, for advertising or promotion purposes (brochures, magazines, newspapers, television, social media, etc.). All materials used remain the property of Camp Kinkora and this session group.

No, Yes

Signature of Parent or legal guardian

RL-24 Tax Credit for Child Care Expenses

Camp Kinkora can provide an RL-24 receipt which is used to claim the Quebec refundable tax credit for a portion of the camp fees that have been paid. Please provide the following information in order to receive the receipt.

Camp Kinkora will not be able to process any incomplete or incorrect forms.

Payer's Name: _____

Childs Name: _____

Payer's Social Insurance Number: _____ Childs Date of Birth: _____
DD MM YYYY

Payer's Home Address: _____

City: _____ Province: _____ Postal Code: _____

Payer's Contact Info: (Tel) _____ Email: _____

Camp Session Dates: From _____ To _____
DD MM YYYY DD MM YYYY

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