



# SAFARI NIAGARA DAY CAMP CAMPER HEALTH INFORMATION FORM

The information provided within this health form is confidential between the camper's parents and Safari Niagara Adventure Day Camp directors and staff. This completed health form must be mailed to Safari Niagara prior to camp session. Campers will not be allowed to attend camp if we do not have their health card number or health insurance numbers on file. Any medications will be collected upon arrival to day camp session.

Name of Camper *(Please print)*: \_\_\_\_\_  
Last Name Given Name

Date of Birth *(Month/Day/Year)*: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal/Zip Code: \_\_\_\_\_

Phone Number *(Home)*: \_\_\_\_\_ Phone Number *(Cell)*: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

**Ontario Residents** - Please be sure that your Provincial Health Card Number information is complete.

Health Card Number: \_\_\_\_\_

Version Code *(Letters at bottom right of card)*: \_\_\_\_\_

Health Insurance Plan & Number: \_\_\_\_\_

Billing Address: \_\_\_\_\_

**In case of emergency** *(when parents are unable to be reached)* please notify:

Contact #1 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number *(Home)*: \_\_\_\_\_ Phone Number *(Cell)*: \_\_\_\_\_

Contact #2 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number *(Home)*: \_\_\_\_\_ Phone Number *(Cell)*: \_\_\_\_\_

Have you any special requests or directions (physical limitations, learning disabilities, behavioral problems, etc.) that you wish the camp health staff to note?

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Height (*Inches & feet*): \_\_\_\_\_ Weight (*Pounds*): \_\_\_\_\_

If a camper has had any of the following, please check:  
(Please note that each camper will have a COVID screening test when arriving each day signed off by a parent or guardian)

- |   |   |  |                                   |  |
|---|---|--|-----------------------------------|--|
| <input type="checkbox"/> Scarlet Fever          | <input type="checkbox"/> Sinus Trouble          | <input type="checkbox"/> Appendicitis  | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chicken Pox     |
| <input type="checkbox"/> Frequent Colds         | <input type="checkbox"/> Sore Throats           | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Hernia   | <input type="checkbox"/> Measles         |
| <input type="checkbox"/> Rheumatic Fever        | <input type="checkbox"/> Discharging Ear        | <input type="checkbox"/> Hay Fever     | <input type="checkbox"/> Asthma   | <input type="checkbox"/> German Measles  |
| <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Whooping Cough         | <input type="checkbox"/> Toothaches    | <input type="checkbox"/> Mumps    | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Incontinence           | <input type="checkbox"/> Past Operations: _____ |  |                                   |  |

Please enter the date of last booster: \_\_\_\_\_

Diphtheria/Tetanus: \_\_\_\_\_ Polio: \_\_\_\_\_

Whooping Cough (Pertussis): \_\_\_\_\_ Measles/Mumps/Rubella: \_\_\_\_\_

Tuberculin Test (And Result): \_\_\_\_\_ Hib Vaccine (Hemophilus): \_\_\_\_\_

Hepatitis A Vaccine: \_\_\_\_\_ Hepatitis B Vaccine: \_\_\_\_\_

Varivax (Chicken Pox): \_\_\_\_\_ Meningitis Vaccine: \_\_\_\_\_

COVID-19 Vaccine: \_\_\_\_\_

Indicate if this person is allergic to any of the following and specify as needed:

Penicillin or other antibiotics: \_\_\_\_\_ Nuts: \_\_\_\_\_

Dairy: \_\_\_\_\_ Animals: \_\_\_\_\_

Bee Stings: \_\_\_\_\_ Any other allergies: \_\_\_\_\_

**Epi-Pen Usage:** Does your child require an epi-pen?  Yes  No

If yes, does your child carry his/her epi-pen with them?  Yes  No

Does your child know how to self-administer their epi-pen?  Yes  No

In case of emergency, do you permit Safari Niagara staff to administer the epi-pen?  Yes  No

Drug Allergies (*Please specify*): \_\_\_\_\_

Additional Allergies; food, etc. (*Please specify*): \_\_\_\_\_

Are there any special medications or injections to be given during the summer:  Yes  No

If yes, please state clearly when and how often they are to be administered: \_\_\_\_\_

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**PLEASE NOTE - ANY MEDICATION SENT TO CAMP MUST BE IN ITS ORIGINAL BOTTLE OR PACKAGE WITH SPECIFIC INSTRUCTIONS.**

Are there any other items of a medical nature that might arise during the summer?  Yes  No  
*(ie. eating disorder)*

If yes, please specify: \_\_\_\_\_

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Has or is your child receiving psychological or group counseling or psychiatric help?  Yes  No

If yes, please specify *(Attach a letter if necessary)*: \_\_\_\_\_

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Doctor's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

If there is on-going medical supervision or care needed, a referral letter from your doctor would be recommended.

To the best of my knowledge this camper is in good health and is physically able to participate in all camp activities except as indicated. To the best of my knowledge, I have provided all relevant medical information for my son/daughter's stay at camp.

In the event of an emergency and/or special medical treatment, parents will be notified immediately. If the parents cannot be reached, permission is hereby given to Safari Niagara Adventure Day Camp to take whatever steps it deems necessary to ensure the safety and health of a camper. This also gives permission to the camp to contact the emergency contact and/or the camper's family physician.

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_