

# CAMP KINKORA

## CAMPER MEDICATIONS LIST

**1. Session**

<b>Session</b>	✓	<b>Session</b>	✓
Diocesan Family Camp 1		Youth In action	
Diocesan Liturgy Camp		Visions	
Diocesan Family Camp 2			

**2. CAMPER identification**

Family name				Given Name			
Medicare No.		Age	Expiry date		Date of birth		
			Month / Mois	Year / Annee	Day / jour	Month / Mois	Year / Annee

**3. CUSTODIAL PARENT**

Family name				Given Name			
Present Address Civic No		Street			Apt.		
City		Province	Postal Code		Telephone		

**4. In case of an Emergency Contact**

The emergency contact individual must be available during the duration of the camp and should be asked if he or she is willing to serve in this role.

Family name				Given Name			
Present Address Civic No		Street / Rue			Apt.		
City / Ville		Province	Postal Code / Code postal		Telephone		

**5. Medical Conditions**

ADD or ADHD		Diabetes		Allergy - Insect Bites	
Asthma		Heart Prouble		Allergy – Penicillin	
Seizures		Hayfever		Allergy –food (specify)	
Other medical information/ Autres particularités médicales					

**6. Medications** (Please list all the medication(s) the camper takes routinely).

Name of medications	Dosage	Specific time taken	Reason

**7. Consent**

**I**, authorize the medical designates of the camp to administer the prescribed medication to my child during his/her stay at camp, and **I** agree to provide the required amount of medication for the duration of his/her stay at camp. **In** case of an emergency **I** authorize camp management to dispense any necessary medical treatment. In the event where it is impossible to contact me, **I** authorize the physician selected by the Camp Director to proceed with necessary medical treatment(s) including; injection, anaesthesia, surgery or hospitalization in order to secure proper treatment for my child and that **I** am obliged to reimburse the camp any medical expenses incurred.

\_\_\_\_\_  
Name of parent or guardian (please print)

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
Date