YOUTH MEDICAL INFORMATION

(Your child's health is important to us and this will help us if there is anything we need to know about them.)
(Please complete fully, this page may be photocopied and kept separate from the application form on the other side.)

Surname	Given Names	Home Phone
Group Name		Cell Phone
Date of Birth: (yyyy-mm-dd)	Medical Plan Number	[ ] Care Card [ ] Provincial [ ] Blue Cross [ ] Other

In case of emergency, please notify:

Name:	Home Phone:	Other Phone:
Name:	Home Phone:	Other Phone:

IF SUBJECT TO ANY OF THE FOLLOWING PLEASE INDICATE:

[ ] Asthma [ ] Cramps [ ] Headaches [ ] Toothache

[ ] Bed Wetting [ ] Fainting [ ] Nightmares [ ] Other: _____

[ ] Bronchitis [ ] Skin Rash [ ] Food Allergies: _____

[ ] Convulsions [ ] Hay Fever [ ] Sleepwalking

PRESCRIPTION OR REGULAR INJECTIONS REQUIRED: [ ] Prescription [ ] Injection

Name of Drug: Frequency: Dosage: [ ] Refrigeration?

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All prescription medication to be taken while in camp must:
1) Be accompanied by a complete medication card.
2) Be in the original pharmacy container and labeled with pharmacy and doctor information.

List Drug Allergies:

List Insect Allergies:

Date of last Tetanus Shot: Date of last Medical Exam:

Name of Family Doctor:	Doctor's Phone #:

Non-Prescription Drugs: Every care and attention will be given to the health and comfort of your child. As your child may be away from home for more than 24 hours, please indicate **yes/no** for the following medications that you **APPROVE/DISAPPROVE** that can be administered to your child under the guidance of an adult First Aider.
These are the medications that may be available at camps, in the event of medical necessity:

Junior Strength Acetaminophen—yes [ ] no [ ] Children's Benadryl—yes [ ] no [ ] Kid's Hurt-Free Polysporin—yes [ ] no [ ]
Junior Strength Ibuprofen—yes [ ] no [ ] Gravol Kids—yes [ ] no [ ] Children's Antihistamine—yes [ ] no [ ]

I, _____ am the parent and/or legal guardian of _____.
I do hereby authorize the BP Service Association to share the medical and personal information contained in this medical information form and to provide first aid and/or secure such medical advice and services (ex: ambulance) as may be deemed necessary for the health and safety of my child/ward and hereby give my permission for my child/ward to attend and participate in all BPSA activities. I understand that I will be notified by the quickest means possible if this authority is exercised.

_____ _____
Signature of Parent/Guardian Date Signed