

CAMPER MEDICAL INFORMATION FORM
TO BE COMPLETED BY FAMILY PHYSICIAN

Please provide the following information thoroughly and legibly and return directly to:

Tamarack Foundation
Box 9677
Saskatoon, SK
S7K 7G5

Camper's Name: _____ Date of Birth: _____

Hospitalization Number: _____ Other Insurance Coverage: _____

Parents' Name(s): _____

Address: _____ Phone Number: _____

Doctor's Name: _____

Address: _____ Phone Number: _____

Emergency Medical Information:

Does the camper have any allergies? Yes No If yes, please indicate below.

Medicine Food Animals Smoke
 Insect Bites Plants Toxins Other

Details: _____

Has had, please check (x)

Appendicitis Mumps Chicken Pox Measles
 Kidney disease Rheumatic Fever Scarlet Fever Heart Condition
 Other (_____)

Is subject to any of the following, check (x) and give details:

Asthma Headaches Fainting Spells Bleeding disorders
 Diabetes Hernia Back Problems Motion sickness
 Cramps Convulsions Sleepwalking Nightmares
 Bed wetting Ear problems HIV Chronic conditions
 Progressive conditions ADHD FASD Autism Spectrum Disorders
 Other (_____)

Details: _____

Vision loss? Yes No If yes: Glasses? Contact lenses?

Hearing loss? Yes No If yes, hearing aid? Yes No

Date of most recent physical examination: (Month and Year): _____

Date of last tetanus shot (Month and Year): _____

Does the camper require activity restrictions, special care, diet or medication? Yes No

Details (please list medications): _____

Has it ever been necessary to restrict the camper's activities for medical reasons? Yes No

Details: _____

Any other areas of concern with this camper? _____

Doctor's Signature: _____ Date: _____