



CAMPER MEDICAL INFORMATION

TO BE COMPLETED BY FAMILY PHYSICIAN

Please provide the following information in a thorough and legible manner and return directly to:
Tamarack Foundation – 510 Cynthia Street - Saskatoon, SK - S7K 7L7

Camper's Name: _____ Date of Birth: _____

Hospitalization Number: _____ Other Insurance Coverage: _____

Parents' Name(s): _____

Address: _____

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 Textiles (wool, latex)

Insect Bites Plants Toxins Other

Details:



Has had, please check (x):

- Appendicitis Mumps Chicken Pox Measles Kidney disease
 Rheumatic Fever Scarlet Fever Heart Condition Lice
 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 Lice (Last Treatment)
 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): _____

Are there any activity restrictions, special care, diets 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 concerns with this camper?

Doctor's Signature: _____ Date: _____