



# HEALTH FORM OF DEPENDANT

THIS FORM HAS BEEN DESIGNED TO GATHER MEDICAL INFORMATION WHICH MAY BE USEFUL DURING YOUR CHILD'S STAY. THIS PREVENTS YOU FROM HAVING TO PART WITH HIS/HER MEDICAL/HEALTH RECORDS. THIS FORM WILL BE GIVEN BACK TO YOU AT THE END OF THE STAY, POSSIBLY INCLUDING SOME OBSERVATIONS.

I. **CHILD:** LAST NAME: \_\_\_\_\_ 1st NAME : \_\_\_\_\_

SEX : 

BOY	<input type="checkbox"/>
-----	--------------------------

GIRL	<input type="checkbox"/>
------	--------------------------

 DATE OF BIRTH : 

/	/	/
dd	mm	yy

II. **VACCINATIONS** (Fill out from your child's medical records or vaccination certificate **AND include photocopies from your child's medical shot records.**)

POLIO – DIPHTHERIA – TETANUS- WHOOPING COUGH

	VACCINATIONS GIVEN	DATES
<i>Specify whether it is:</i>		// //
Diphtheria Tetanus Polio vaccination		// //
Diphtheria Tetanus Whooping-cough vaccination		// //
Diphtheria Tetanus Whooping-cough polio update vaccination		// //
updated polio vaccination		// //
Hepatitis B vaccination		// //
<b>BOOSTERS</b>		// //

TUBERCULOSIS		SMALLPOX		OTHER VACCINATIONS	
	DATES		DATES	VACCINATIONS GIVEN	DATES
1st VACCINATION		VACCINE			
2nd VACCINATION			1st BOOSTER		

IF YOUR CHILD HAS NOT BEEN VACCINATED, WHY ? \_\_\_\_\_

	TYPE	DATES
SERUM INJECTIONS		

### III. MEDICAL INFORMATION ABOUT YOUR CHILD

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING SICKNESSES :

GERMAN MEASLES	CHICKENPOX	TONSILLITIS	RHEUMATISM	SCARLET FEVER
NO <input type="checkbox"/> YES <input type="checkbox"/>	NO <input type="checkbox"/> YES <input type="checkbox"/>	NO <input type="checkbox"/> YES <input type="checkbox"/>	NO <input type="checkbox"/> YES <input type="checkbox"/>	NO <input type="checkbox"/> YES <input type="checkbox"/>
WHOOPING COUGH	EAR INFECTION	ASTHMA	MEASLES	MUMPS
NO <input type="checkbox"/> YES <input type="checkbox"/>	NO <input type="checkbox"/> YES <input type="checkbox"/>	NO <input type="checkbox"/> YES <input type="checkbox"/>	NO <input type="checkbox"/> YES <input type="checkbox"/>	NO <input type="checkbox"/> YES <input type="checkbox"/>

INDICATE HERE OTHER HEALTH PROBLEMS, SPECIFYING THE DATES :  
(sicknesses, accidents, convulsions, allergies, hospitalizations, operations, rehabilitations)

	// //
	// //
	// //

IV. RECOMMENDATIONS OF THE PARENTS

IS YOUR CHILD CURRENTLY UNDERGOING ANY MEDICAL TREATMENT?

NO

YES

IF YES, WHAT KIND? \_\_\_\_\_

*IF YOUR CHILD MUST UNDERGO A MEDICAL TREATMENT DURING HIS/HER STAY, DON'T FORGET TO INCLUDE THE PRESCRIPTION FOR HIS/HER MEDICINE*

DOES YOUR CHILD WET HIS/HER BED ?

NO

OCCASIONALLY

YES

IF YOUR CHILD IS A GIRL, HAS SHE HAD HER 1<sup>ST</sup> MENSTRUAL CYCLE?

NO

YES

V. PERSON RESPONSABLE FOR THE CHILD :

LAST NAME: \_\_\_\_\_ FIRST & MIDDLE NAMES : \_\_\_\_\_

ADDRESS (DURING THE TIME OF THE CHILD'S STAY) : \_\_\_\_\_

SS # \_\_\_\_\_

TEL #. \_\_\_\_\_

HOME \_\_\_\_\_

OFFICE \_\_\_\_\_

ADDRESS OF MEDICAL INSURER : \_\_\_\_\_

I the undersigned, responsible for the child, declare all information provided on this form to be correct, and I authorise the persons in charge of the stay, if need be, to take all measures (medical treatments, hospitalizations, surgical interventions) made necessary by the condition of the child.

Signature :

DATE :

**PART RESERVED FOR CAMP ORGANIZER**

PLACE OF STAY :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Organization's Seal/Stamp (head office)

[Large empty box for seal/stamp]

ARRIVAL

\_\_\_\_\_  
\_\_\_\_\_

DEPARTURE

\_\_\_\_\_  
\_\_\_\_\_

**OBSERVATIONS DURING THE COURSE OF THE CHILD'S STAY**

BY THE DOCTOR

(who will note his name, address and telephone #)

BY PERSON IN CHARGE OF THE STAY

(who will note his name and address)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_