

Trillium Childhood Cancer Support Centre Parent Camper Health Record 2011/12

Please Print

(In effect June 1/2011 – May 31/2012)



Name _____
Last First Middle

Birth date _____ Sex Male Female
mm/dd/yy

Home address _____
Street Apt

City Province Postal Code

Telephone (_____) _____ Cell (_____) _____

Language English French Other _____

Family Names Patient's Last Name _____ Other Family Member Last Names _____

In case of an emergency, please notify _____

Relationship to you _____ Home (_____) _____ Work (_____) _____ Cell (_____) _____

PARENT ROLE Parent of child **ON** treatment for cancer
 Parent of child **OFF** treatment for cancer since _____ (mm/dd/yy)
 Bereaved parent since _____ (mm/dd/yy)

For emergencies and for medication administration purposes, please provide a recent picture of yourself

For valuable consideration, Camp Trillium allowing myself _____ to participate in its activities, agree to the following:

In order to enhance experiences and provide a safe environment, all persons attending Trillium programs are asked to provide certain medical and social information. This information may be shared with the Trillium Health Care Team, the counseling staff, the clinic team at the nearest POGO center, or with other personnel in the case of an emergency. Furthermore, information may be transferred and stored electronically. However, the release or transmission of any sensitive information (medical or otherwise) will be at the discretion of the Director of Nursing or his or her delegate. Furthermore, some of the biographical and/or medical information you provide may be used in program evaluation and/or research but not without the approval of the Executive Director. By signing this consent you are agreeing to the transmission and/or use of the medical/social information you have provided for the purposes described above.

I give my permission to the medical personnel of Camp Trillium or to the medical personnel selected by Camp Trillium to act on my behalf and administer the necessary medical care to me, including transportation by employees, officers or agents of Camp Trillium for medical care.

Trillium Childhood Cancer Support Centre requests personal information about campers and families, such as name, address,

phone number, email, and history of illness and treatment. This information is gathered to provide service that Camp Trillium offers, to communicate with you via the newsletter and other mailings, to obtain medical and emergency care if required, to support promotional information (i.e. fundraising) and to facilitate ongoing communication. We respect and protect the privacy of our campers. We will not share your information with third parties; or divulge information to other organizations or individuals for the purpose of self or product promotion under any circumstances other than described here. Trillium will endeavor to honour any request you make to access or review the personal information collected.

We consider your provision of personal information to Camp Trillium to be your consent to your collection, use and where required disclosure of personal information as described above. In certain circumstances you may withdraw your personal information. For further information please contact our Privacy Administrator.

This health record is correct and complete as far as I know. This form shall remain in full force and effect until it is withdrawn or amended by giving notice to: Camp Trillium 940 Queensdale Ave. East, Hamilton, Ontario L8V 1N4

I agree that no notice apart from that, which is specified above, shall be considered to amend this form.

This form shall bind me, my representatives, successors and/or administrators.

Signature: _____

Printed Name: _____ Date: _____

Signature of Witness: _____

Printed Name: _____ Date: _____

HEALTH CARE INFORMATION

Health card _____ Version code _____ Province _____

Family Doctor _____ Telephone(_____) _____

Other Health Care Professionals / Specialists

Name _____ Specialty _____ Telephone(_____) _____

Name _____ Specialty _____ Telephone(_____) _____

GENERAL HEALTH QUESTIONS

Do you have/or have had:

	Yes	No		Yes	No
Recent Illness or Injury	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chronic or Recurring Illness or Condition	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Female: Pregnant /Abnormal Menstruation	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Walking/Orthopedic Problems	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Emotional / Mental Health Problems	<input type="checkbox"/>	<input type="checkbox"/>
Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clotting Problems	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
Stomach/ Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>			

Please provide details here for questions answered yes:

Have you ever been told not to participate in any activities by a health professional? Yes No

Please explain:

ALLERGIES

	Yes	No	Unknown	Anaphylactic*	Give details, past reactions and usual treatment
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bee Stings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Peanuts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER (food, latex, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**all anaphylactic campers need to bring a prescription labeled, not expired epi-pen or twinject device to camp.*

NUTRITIONAL INFORMATION Please check all that apply:

do not eat red meat do not eat pork do not eat eggs do not eat dairy products other

MEDICATION Will you require medication while at camp? Yes No Unsure

*Please bring all medications usually taken, in **originally labeled containers**, and enough for your entire stay at camp.*

Medication	Dose	Times taken	Reason/ Diagnosis	Special instructions

IMMUNIZATION

	Yes	No	Date (mm/yy)
MMR (measles, mumps, rubella)	<input type="checkbox"/>	<input type="checkbox"/>	____/____
DPT (diphtheria, tetanus, pertussis)	<input type="checkbox"/>	<input type="checkbox"/>	____/____
Tetanus booster.....	<input type="checkbox"/>	<input type="checkbox"/>	____/____
<i>If your last DPT, or last tetanus booster was >10 years ago, a tetanus booster is recommended prior to coming to camp.</i>			
Chicken Pox (Varivax).....	<input type="checkbox"/>	<input type="checkbox"/>	____/____
Hepatitis B.....	<input type="checkbox"/>	<input type="checkbox"/>	____/____
Other Vaccines (please list) _____			____/____

ILLNESS

	Yes	No	Unsure	Date (mm/yy)
Chicken Pox.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____
Shingles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____
Measles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____
Mumps.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____
Other.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____/____