



EMERGENCY MEDICAL INFORMATION

Confidential Document - for Club Use Only

Name of ICFC camper: _____

Name of Parent(s) or Guardian: _____

Address: _____

Telephone numbers: Home: _____

Work: _____

Parent Cell: _____

Name, relationship, and telephone numbers of person to contact in the event of a medical emergency if parent or guardian cannot be reached:

Physician's name, address, telephone numbers:

Date of most recent tetanus shot: _____

Please indicate any chronic health problems:

☐ None

☐ Epilepsy

☐ Kidney or liver disease

☐ Heart disease

☐ Blood disease

☐ High blood pressure

☐ Nervous disorder

☐ Asthma

☐ Prolonged bleeding after a cut or surgery

☐ Diabetes

☐ Allergies

☐ Kidney stones

☐ Other: _____



Please list the prescription medication(s) the camper will take while at camp; provide a medical order for administration:

☐ None needed while at camp.

- a. _____
- b. _____
- c. _____

Please list any medication(s) – prescription or over the counter – the camper is forbidden to take:

☐ None needed while at camp.

- a. _____
- b. _____
- c. _____

Please list the allergies (food, medication, etc.) of the staff member: ☐ No known allergies

- a. _____
- b. _____
- c. _____

Note: Our expectation is that the camper will have multiple EpiPens and know how to use them if anaphylaxis is part of the individual's health profile.

Please describe any other treatment needed by the camper to do his/her job: ☐ None needed

Is there anything of a social, psychological, or emotional nature you would like us to understand about the camper that would assist us in meeting his/her needs?

☐ No additional comments needed



By signing this form, you are confirming that your child is both physically *and emotionally* ready to participate at Iron City Fishing Club.

I hereby give permission for my son/daughter (name _____) to receive medical care should this be indicated by the camp doctor of the Iron City Fishing Club. This includes permission to transport the patient to an appropriate medical facility, usually the Parry Sound Hospital, Parry Sound, Ontario, Canada.

SIGNATURES (both parents or guardian):

Parent Name

Parent Signature

Date

Parent Name

Parent Signature

Date