CHEAKAMUS CENTRE
nature is in session

MEDICAL FORM

Name:			School/Group:
Age:	Date of Birth:	Gender:	Program Date:
Address:			
Provincial Care Card #:			Other Health Insurance:
Parent/Guardian:			**Emergency Contact:**
Email:			Relationship:
Phone:			Phone:
Alternate phone:			Alternate phone:

DIETARY INFORMATION

Cheakamus Centre is a nut restricted facility. We do not order, import or permit any products containing nuts on site. We cannot, however, fully guarantee that private individuals are not bringing items containing nut products on site for personal consumption or use.

Food Allergy	**Reaction** **Please bring Epi Pen if required for anaphylactic reactions.*	**Epi Pen Required?**		**Trace amount OK?**		**Baking OK?**	
		Yes	No	Yes	No	Yes	No
		☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐

Food Restrictions:

- ☐ Gluten Free
- ☐ Celiac Disease
- ☐ Vegan
- ☐ No Pork
- ☐ No Red Meat
- ☐ Lacto-ovo-vegetarian (eggs & dairy OK)
- ☐ Pescetarian (fish, eggs & dairy OK)
- ☐ Lacto Vegetarian (dairy OK)
- ☐ Other: _____

☐ **Lactose Intolerant** → ☐ Small Amounts OK ☐ Baking OK ☐ Ice Cream OK ☐ Cheese OK

IMPORTANT: For highly restrictive diets, parents may be required to provide supplementary food items. Please contact your school or group planning lead for more information.

HEALTH INFORMATION

Include details in notes section below or attach a separate sheet if necessary. Children with diabetes or other significant medical conditions are required to attach a detailed care plan.

- ☐ Diabetes
- ☐ Seizure Disorder
- ☐ Heart Condition
- ☐ Asthma
- ☐ Hearing Aid
- ☐ Recent Concussion
- ☐ Migraine Headache
- ☐ Recent Injury
- ☐ Frequent Infection
- ☐ ADHD
- ☐ Autism
- ☐ Anxiety/Phobia
- ☐ Bedwetting
- ☐ Sleepwalking

Notes: _____

Allergies (Environmental or Medications)	**Reaction**	**Treatment**

Prescribed Medication: *Please list all medications the participant will be taking while at Cheakamus Centre.*
LIST: what it is used for, dosage, how it is to be given, and times given. Ensure medications are clearly labelled with this information.

(attach separate sheet if necessary)

Consent to MEDICAL TREATMENT In the event of a medical emergency, if I am not immediately contactable, I give my consent to treatment to the health care providers (doctors, hospital medical staff, first aid attendants) chosen by the management of Cheakamus Centre, in consultation with visiting teachers, to provide whatever treatment is medically necessary for the Participant. I have completed this medical form accurately, truthfully, and to the best of my knowledge as of today's dates.

_____ _____

Signature of adult participant OR custodial parent/guardian for children | Date (M/D/Y)