

TO BE COMPLETED BY A PARENT OR LEGAL GUARDIAN

Camper's Name	<input type="text"/>	Birth date	<input type="text"/>	Wt.(kg)	<input type="text"/>
Parent/Guardian	<input type="text"/>				
Primary # ()	<input type="text"/>	Secondary # ()	<input type="text"/>		
Address (City/Prov/Postal code)	<input type="text"/>				
Alternate emergency contact (name/relationship)	<input type="text"/>				
Primary # ()	<input type="text"/>	Secondary # ()	<input type="text"/>		
Provincial health care card #	<input type="text"/>				
Private insurance carrier name	<input type="text"/>	Policy / group #	<input type="text"/>		
1. list any health issues/conditions	<input type="text"/>				
2. Current medication(s) camper is taking (instructions, dose and frequency)	<input type="text"/>				
3. Allergies camper has including reaction and/or use of epipen	<input type="text"/>				
4. Operations or serious injuries (dates/explain)	<input type="text"/>				
5. Specific activities to be encouraged or limited by physician's advice	<input type="text"/>				
6. Name of Physician	<input type="text"/>	Phone # ()	<input type="text"/>		
7. Food allergies or specific dietary needs (vegetarian etc.)	<input type="text"/>				
8. While at Fusion the camper may receive common over the counter medications (i.e. Advil/Tylenol, Benadryl etc.) if deemed appropriate by the health care professional selected by Fusion.					Y <input type="checkbox"/> N <input type="checkbox"/>
<p>I understand that a Fusion staff member will be dispensing medication per the instructions of the parent and understand that medication will be distributed in accordance with the directions provided and that those directions may be conveyed to medical providers in case of an emergency. EMERGENCY AUTHORIZATION: I authorize any representative of Fusion to seek medical attention for my child when immediate medical care is warranted by the circumstances and I cannot be reached, or if under the circumstances there is no time to attempt to reach me because of the nature of the injury or illness. I further authorize the health care professional selected by Fusion to provide the necessary care and treatment for my child.</p> <p>This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed Fusion activities except as noted above.</p>					
Signature of the Parent or Legal Guardian <input checked="" type="checkbox"/>					Date <input type="text"/>

CONTACT INFORMATION & ATTENDEE HEALTH HISTORY