MEDICAL ACKNOWLEDGEMENT

Campers must have the information on this form completed and signed by a practicing licensed physician or Nurse Practitioner.

If your transplant was **LESS than 1 (one) year ago**, please have this form completed by your transplant specialist. Otherwise, please ask your transplant/medical team whether they want to complete this form or whether your family doctor should complete this form.

Note to Physician/Nurse Practitioner completing form: The person being evaluated will be attending one week of camp. The experience may include sleeping on the ground and participating in activities such as hiking, canoeing and large group games. Please review the health history with the participant for any interim changes. Any questions regarding this child's suitability for camp please contact Christina Belza (Camp Medical Director) at campkivita@gmail.com or 416-909-2863.

NAME OF CAMPER: _____

Date of Birth (D/M/Y):_____ Date of Exam:_____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Drug Allergies: _____

Other Allergies: _____

Please List Any Current Problem(s):

Please List ANY Surgeries Including the Date and Procedure:

Physical Exam: Please list any pertinent findings or attach a recent clinic note

Age: _____ Weight: _____ Height: _____

BP:____ /____ Pulse: _____

Vision: Normal Glasses Contacts

Hearing: Normal Abnormal Explain:_____

Additional findings:

_____

_____

_____

Medications:
(Note: We realize that medications and schedules may change before the summer; a "late changes" form will be included in the camper's final approval packet which will be brought to camp with the camper. All campers are responsible for bringing their own medications and supplies).

Please use this list as a guide or attach a list to this package

Medication	Dose	Frequency/Administration time

Regarding this child's social development, would s/he communicate and interact with peers and others in an age appropriate manner? Yes _____ No _____

If no, please explain:

Are there any behavioural or mental health concerns that would affect this child's participation at camp?

Below are the activities campers will have the opportunity to participate in. Please check off any activities that **WOULD NOT** be safe for this child.

- ☐ High ropes/Climbing wall
- ☐ Canoe/Kayaking
- ☐ Arts and Crafts
- ☐ High Energy Games
- ☐ Outdoor Games
- ☐ Sharing Room and Washroom
- ☐ Tennis
- ☐ Running/Walking
- ☐ Swimming/Water activities
- ☐ Archery
- ☐ Outdoor Cooking/Camp Fires

I _____ have examined

_____ and find him/her able to attend camp.

This camper needs to have an updated medical review 4 weeks prior to camp:

YES_____ NO_____

Signature of Physician/NP _____

Printed Name _____

Date: _____

Address: _____

Phone: _____

Please return form to Camper or send directly to Camp:

Camp Wenonah, 1-3540 Commerce Court,

Burlington, ON, Canada L7N 3L7

Fax: (905) 631-2850

Email: info@Campwenonah.com