



Foundation for Eating Disorders

Session Date: August 23th-30th

Please return to Camp Administrator
9504 Erickson Dr
Burnaby, BC
V3J 1M9
administrator@lookingglassbc.com
Fax: 604-986-6011

2009 Camper and Medical Information Form for Looking Glass Camp at Loon Lake

Campers full name _____
Age _____ Birth Date _____ Gender _____
Address _____ City _____ Province _____
Postal Code _____ Phone () _____ Alternate number () _____
Nickname _____ Grade in School _____ Email Address _____
Place of Birth: _____ Primary Language _____
Does he/she speak English Yes No

Diagnosis _____
Camper's Medical Number _____
Dr's Name _____ Family Dr's Phone Number () _____
Specialist Name _____ Phone Number _____
Hospital _____

NAME OF PARENT(S) OR GUARDIAN(S) CHILD LIVES WITH			
NAME	RELATIONSHIP	WORK PHONE:	CELL PHONE:

If child does not live with both guardians which has legal custody?

Name of non-residential guardian:

Home Phone: () _____ Cell Phone: () _____



Emergency Contact

Person to be contacted in case of emergency if parents cannot be reached:

Name _____ Relationship _____

Home Phone: _____ Work Phone: _____ Cell: _____

Name/phone of person authorized to pick up your child if unavailable on closing day: _____

Child's Name: _____

Date Attending Camp: August 23th-30th

General Medical History

Name of Physician who should be contacted	
Pediatrician:	Other Doctor:
Institution:	Institution:
Address:	Address:
Phone:	Phone:
Emergency Phone:	Emergency Phone:
Pager: Email:	Pager: Email:

Please describe your child's concerns:

Drug Allergies: _____

Is your child subject to, or has had:

- Tuberculosis
- Measles
- Epilepsy
- Chicken pox
- Frequent colds
- Heart condition
- German Measles
- Migraines
- Rheumatic fever
- Hay fever
- Eczema

- Bronchitis
- Mumps
- Asthma
- Ear Infections
- Appendicitis
- Diabetes
- Seizures
- ADD/ADHD
- Kidney Disease
- Hepatitis
- HIV

Are there any activities that your child should not participate in at any level? Please list:



Has your child been recently hospitalized? Yes No

Does your child have the ability to walk without requiring a rest?

Yes No

Comments:

Physical Restrictions or limitations wheelchair crutches/cane walker

splint/brace amputation artificial limb hearing impaired vision impaired

Additional Information:

Special needs/care requirements (psychological/social behaviour, develop, delay, etc)

Please list any other known medical problems or special needs of your child that we should be aware of

Immunizations

Are your child's immunizations up-to-date? Yes No

If no, what is missing?

Year of last Tetanus
(dpt,dt)



Foundation for Eating Disorders



Child's Name: _____
Date Attending Camp: _____

Medication

Note: All medications administered at Camp (including over-the-counter medicines and vitamins) must appear on your child's physical form

Each family should send all medications and any other supplies necessary for their child while at camp. The medical staff will store and administer medications as directed by you.

DRUG NAME	DOSE	FREQUENCY
Supplemental Nutrition:		

* Please indicate any special ways to give medications. Include information about medications used to prevent nausea and vomiting and pain management if applicable. We know that medication schedules may change before the summer. All Medications should be blister packed; Pharmacies will do this for free.



Foundation for Eating Disorders

Child's Name: _____
Date Attending Camp: _____

Privacy policy

The Looking Glass Foundation is committed to protecting personal information by following responsible information practices. We will keep your child's personal data safe and secure in order to better meet your service needs, to ensure the safety of children in our care, for statistical purposes, to inform you about The Looking Glass Foundation program of service in which you are registered, and to satisfy government and regulatory obligations.

I, Authorize staff of The Looking Glass Foundation to administer over the counter medication on an as needed basis. Example: giving my child pain medicine when he/she has a headache.

Signature _____

Authorization for use of Photos

I authorize The Looking Glass Foundation to use any photos of my child while engaging in Camp programs.

Date _____ **Signature** _____





Foundation for Eating Disorders

Child's Name: _____
Date Attending Camp: _____

Waiver and Consent for Medical Treatment

I _____ hereby grant permission to the nurses, staff and consulting physicians at the Looking Glass Camp at Loon Lake to administer medication and provide medical and other care for my child, including transportation deemed necessary or appropriate in the sole discretion the Looking Glass Foundation, in connection with the treatment of my child. I also assume full financial responsibility for any and all medical and other expenses incurred for or on behalf of my child while at the Looking Glass Foundation or offsite. I understand, all information pertaining to my child, will be treated confidentially by, the Looking Glass Foundation. However, I agree that said information may be shared with/released to appropriate personal and/or third parties the Looking Glass Foundation for the purpose of treating and/or supervising my child (including, but not limited to nursing, medical and other camp staff. Insurance companies).

In permitting my child to attend the Looking Glass Camp at Loon Lake, I, the undersigned permit my child to participate in the full range of camp activities and authorize the Camp Director or his/her appointee, in the event of accident or illness affecting this above named camper to authorize on my behalf all procedures, including admission to hospital and necessary treatment therein, as he/she may deem essential for the care and well being of the camper. Such action is only to be taken when immediate contact with the undersigned cannot be made. It is understood that the camp is not responsible for medical care costs.

Assumption of all Liability

I, the undersigned Parent/Guardian assume full responsibility for any damage or destruction of camp property as a result of the actions of my child, and I understand that I will be billed for and such damage and/or destruction.

I FULLY UNDERSTAND AND AGREE TO THE TERMS STATED ABOVE.

Parent/ Guardian Signature

Date





Foundation for Eating Disorders

Child's Name: _____
Date Attending Camp: _____

Social and Emotional Adjustment

The following questions have been designed in order to best assist both your child and staff to have a safe and memorable experience at The Looking Glass Camp at Loon Lake. Not all activities at camp may be suitable or feasible for every camper. Whenever possible an appropriate alternative activity will be provided.

1. How does your child interact in a group of children the same age?

2. How often does your child require close supervision? Please provide accurate examples!

All of the time

Examples:

Some of the time

Examples:

None of the time



3. How does your child respond to authority figures/adults, when:

Happy: _____

Angry: _____

Frustrated: _____

Sad: _____

4. Please provide any other important information that would be beneficial for the Staff of the Looking Glass Foundation to provide the ultimate camp experience!

