



# CJ' 17 Health Information Form



## About You

First Name		Middle Name		Last Name:	
DOB (YYYY/MM/DD):		Gender:		OOS# (OOS only)	
Scout Group Name:				Preferred Language:	
Home Province (Canadian residents):		Provincial Health Card Number (Canadian residents):			

### Supplemental health insurance details, if you are covered by an additional plan

- Insurer (e.g. SunLife, Blue Cross, etc.):
- Plan Number:
- Primary Plan Holder (if not you):
- Relationship to Plan Holder:

## Emergency Contact Information

Who should we contact in case of an emergency?

Name	Phone Number	Relationship	Where will they be during Jamboree? (e.g. at home, at Jamboree, on vacation in ___):
------	--------------	--------------	--

## Allergies and Food Requirements

Do you carry an epinephrine auto-injector (e.g. "EpiPen <sup>®</sup> ")?		(If yes, specify details of allergy below.)
--	--	---

What are you allergic to?

Allergy to...	Method of Exposure*	Describe Reaction	Usual Treatment
---------------	---------------------	-------------------	-----------------

\*ingested, inhaled, contact, injected, and/or all of the above or part of above. Attach additional information on Appendix A, if required

Do you have any religious or special dietary needs (e.g. Halal, Kosher, Vegetarian)?

Do you have any specific dietary preferences, intolerances, or allergies? If so, specify.

Food / Food Group	Details**

\*\* preference / intolerance / allergy Enter additional information on [Appendix A](#), if required

## Health Professionals

Include the contact details of physicians, nurse practitioners, dentists, or a family health team:

Name	Type	Phone	Situation Details

If you have any specialists looking after you who should be contacted when you receive care, please list in the table above or attach additional information listing their names, contact information, and situations in which they should be contacted.

## Immunization

Have you been immunized for...

	Yes/No	Had	If yes, year & month of last immunization
tetanus?		■	
chickenpox?		■	
measles, mumps, and rubella (MMR)?		■	
meningitis?		■	

## Medications

Ensure all medications sent to camp are unexpired, clearly labeled, and with enough supply to last the entire Jamboree. Always send some extra, just-in-case.

Medication and Dose (e.g. Rampiril 5mg)	Frequency (e.g. once a day, at breakfast)	For What Condition is this Taken? (e.g. high blood pressure)

Enter additional information on [Appendix A](#), if required

If you do not wish to receive any specific over-the-counter medications, please provide details in [Appendix A](#).

## Medical Conditions

Do you have any of the following, or a history of any of the following? (please select a choice for each)

	No/Yes	If yes, please specify:
Conditions affecting <b>vital signs</b> (e.g. pulse rates, pupils, blood pressure measurements, etc.)		
Conditions affecting the <b>senses</b> (e.g. sight, sound, touch, etc.)		
Conditions affecting <b>sleep</b> (e.g. sleepwalking, nightmares, etc.)		
Conditions affecting <b>behaviour or communication</b> (e.g. ADHD, autism spectrum, etc.)		
Diabetes		type / usual management / usual or target range:
Angina / Heart Attacks		usual frequency / usual management:
Other Heart Condition(s) (e.g. arrhythmia)		if condition is episodic, usual management:
Seizures		usual frequency / known triggers, if any / specific management:
Asthma		known cause(s), if any / usual management:
COPD (including emphysema, bronchitis)		usual management:
Appendicitis		
Communicable Conditions, blood-borne or otherwise		name of condition(s):
Other:		

## Assistive Devices and Technologies

Do you use any assistive devices, tools, or technologies?

(e.g. glasses, contact lenses, hearing aids, walker, cane)

--

## Other

[for youth ONLY] If a treating physician determines that your youth should receive a tetanus immunization, would you like that immunization to be given?

--

**MEDICAL EMERGENCY PROCEDURES CONSENT:** Residents of all Provinces/Territories except Quebec: Experience has shown that in connection with Scouting activities there are times when illness or accident may occur and immediate surgical or medical attention is necessary. This is my permission for the Scouter in charge, or designate, to make arrangements for qualified surgical or medical attention for my son/ daughter/ward in the event of an emergency without necessity of my prior approval. I understand that I will be notified by the quickest means possible if this authority is exercised.

**MEDICAL EMERGENCY PROCEDURES CONSENT: RESIDENTS OF QUEBEC:** Experience has shown that in connection with Scouting activities there are times when illness or accident may occur and immediate surgical or medical attention is necessary. In the event of an emergency in which my child's life is in danger or his/her integrity is threatened and I cannot be reached to provide consent, I agree that care may be provided to my child without my consent, as contemplated in paragraph 1 of article 13 of the Civil Code of Quebec. I understand that I will be notified by the quickest means possible if this authority is exercised.

Name and relationship to youth	Date (yyyy-mm-dd)

## Additional Information – Appendix A

### Additional Details