L.C.A.P. 2023

Leaders in the Crusader Athletic Program

**Sunday August 27 – Friday September 1, 2023**

**Leadership Camp @ Camp Brébeuf - GRADE 7&8 BOYS & GIRLS**

**Registration Form:**

**Return to: C.Y.O. 5999 Chippewa Road, Mount Hope, ON L0R 1W0 OR EMAIL:** [**carla.underhill@cyo.on.ca**](mailto:carla.underhill@cyo.on.ca)

Once registered, a confirmation letter will be sent to you with more information regarding camp.

For more information, please contact Carla Underhill; 905-528-0011ext 3604 or [carla.underhill@cyo.on.ca](mailto:carla.underhill@cyo.on.ca)

**CAMPER INFORMATION:**

Full Name: Click or tap here to enter text.

Date of Birth (D/M/Y): Click or tap here to enter text. Gender: M  F  Other

(If selecting other, which cabin would you feel most comfortable sleeping in?) Male  Female   
School: Click or tap here to enter text. Grade: Click or tap here to enter text. (Completed)

Address: Click or tap here to enter text.City: Click or tap here to enter text.Postal Code:Click or tap here to enter text.

Ontario Health Card #: optional Click or tap here to enter text.

Exact Name: Click or tap here to enter text.

Parent 1/Guardian Name: Click or tap here to enter text.Email: Click or tap here to enter text.Cell#: Click or tap here to enter text.  
Parent 2/Guardian Name: Click or tap here to enter text. Email: Click or tap here to enter text.Cell#: Click or tap here to enter text.

Emergency Contact: Click or tap here to enter text. Telephone: Click or tap here to enter text.

Family Doctor: Click or tap here to enter text.Telephone: Click or tap here to enter text.

**IMMUNIZATIONS:** (Please check)

Polio  Tetanus  Pertussis  Diphtheria

**Medical History:** If camper has had or has any of the following, please check

Chicken Pox

Measles, Red

Measles, German

Sleep Walking

Hay Fever

Diabetes

Mumps

Whooping Cough

(recent)

Bed Wetting

Sinus Trouble

Rheumatic Fever

Spells/Fainting any kind

Severe Stomachaches

Frequent Colds

Asthma

Hepatitis

Hernia

**Health Declaration and Emergency Authorization**

To the best of my knowledge, this camper is in good health, does not have a communicable disease and is able to participate in all aspects of the camp program. If he/she becomes exposed to any infectious disease four weeks prior to camp, I understand that the Camp Director must be notified in writing. I give permission for the medical information provided to be shared with the appropriate camp staff and outside personnel as necessary.

**Authorization for Emergency Treatment**

In case of an emergency and we are not immediately available for consultation, I hereby give permission to the physician selected by the Camp Director, to hospitalize, secure proper medical treatment for and order injections, anesthesia or surgery for my child, as named above with the cost of necessary prescriptions and medical expenses to be borne by me.

Name of Parent/Guardian(please print): Click or tap here to enter text.

Signature of Parent/Guardian): Click or tap here to enter text. Date: Click or tap here to enter text.

*Medical Information Form*

**Medication**

All medication, vitamins etc. must be turned over to the Wellness Coordinator at registration. Medication

should be brought to camp appropriately labeled for each camper.

Please indicate if camper will bring his or her own  **EPI Pen** or  **Inhaler.**

Please list any medications your child will bring to camp (attach list if more space is needed):

|  |  |  |  |
| --- | --- | --- | --- |
| **Health Condition** | e.g. Asthma, ADHD | Click or tap here to enter text. | Click or tap here to enter text. |
| **Medication Name / Treatment** | e.g. Salbutamol, Risperdal | Click or tap here to enter text. | Click or tap here to enter text. |
| **Dosage and Form** | e.g. 2 puffs inhaler,  1.5.mg pill | Click or tap here to enter text. | Click or tap here to enter text. |
| **Times to Administer** | e.g. As needed, 8am | Click or tap here to enter text. | Click or tap here to enter text. |

**Allergies**

Please describe any allergies your child may have to the following (attach list if more space is needed):

|  |  |  |  |
| --- | --- | --- | --- |
| **Allergy** | e.g. wasps, pollen | Click or tap here to enter text. | Click or tap here to enter text. |
| **Exposure** | e.g. airborne, ingested, physical contact | Click or tap here to enter text. | Click or tap here to enter text. |
| **Reaction** | e.g. life-threatening, anaphylaxis, itchy eyes | Click or tap here to enter text. | Click or tap here to enter text. |
| **Treatment** | e.g. EPI Pen, Claritin as needed | Click or tap here to enter text. | Click or tap here to enter text. |

**Dietary Restrictions**

Lactose-intolerant  vegetarian: (e.g. lacto-ovo, vegan, no red meat) Click or tap here to enter text.

Celiac  other (please describe) Click or tap here to enter text.

**Other Relevant Information**

Please describe other relevant medical information including health conditions not treated with medication, recent operations, illness or injuries this camper has had and give details: Click or tap here to enter text.

**Method of Payment OPTIONS: CHEQUES/E-TRASFER/VISA/MATERCARD/DEBT: $350.00**

Cheques payable to: C.Y.O. (MAIL: 5999 CHIPPEWA RD E. MOUNT HOPE,ON L0R 1W0)

CHEQUE $Click or tap here to enter text. is enclosed/MEMO LCAP 2022

E-TRANSFER: [boguslava.rak@cyo.on.ca](mailto:boguslava.rak@cyo.on.ca)

DEBIT: call in 905-528-0011 EXT.3604

Visa  MasterCard Card Number: \_\_ \_\_ \_\_ \_\_/ \_\_ \_\_ \_\_ \_\_/ \_\_ \_\_ \_\_ \_\_/\_\_ \_\_ \_\_ \_\_

Amount $Click or tap here to enter text. Expiry Date: (month)\_\_\_\_\_\_\_\_\_\_\_\_ (year)\_\_\_\_\_\_\_\_\_

Cardholder Name: Click or tap here to enter text.

Cardholder Signature: Click or tap here to enter text.

For office use only: Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_