

# L.C.A.P.

## Leaders in the Crusader Athletic Program

**Sunday August 25 - Friday August 30, 2019**  
**Leadership Camp @ Camp Brébeuf**  
**GRADE 7&8 BOYS & GIRLS**

**Registration Form:**

**Return to: C.Y.O. 5999 Chippewa Road, Mount Hope, ON L0R 1W0.** Once registered, a confirmation letter will be sent to you with more information regarding camp and bus transportation (optional).

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

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Gender: M  F  School: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Month/ Day / Year completing

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Ontario Health Card # : optional \_\_\_\_\_

Exact Name: \_\_\_\_\_

Parent 1/ Guardian Name: \_\_\_\_\_ Home#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Parent 2/Guardian Name: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell#: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Telephone: \_\_\_\_\_

**IMMUNIZATIONS:** (Please check)

Polio  Tetanus  Pertussis  Diptheria

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Chicken Pox     | <input type="checkbox"/> Mumps                    | <input type="checkbox"/> Severe Stomach aches |
| <input type="checkbox"/> Measels, Red    | <input type="checkbox"/> Whooping Cough           | <input type="checkbox"/> Frequent Colds       |
| <input type="checkbox"/> Measels, German | (recent)  | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Sleep Walking   | <input type="checkbox"/> Bed Wetting              | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> Hay Fever       | <input type="checkbox"/> Sinus Trouble            | <input type="checkbox"/> Hernia               |
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Rheumatic Fever          |   |
|  | <input type="checkbox"/> Spells/Fainting any kind |   |

**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): \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



## Medical Information Form

### Medication

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

<b>Health Condition</b>	e.g. Asthma, ADHD		
<b>Medication Name / Treatment</b>	e.g. Salbutamol, Risperdal		
<b>Dosage and Form</b>	e.g. 2 puffs inhaler, 1.5.mg pill		
<b>Times to Administer</b>	e.g. As needed, 8am		

### Allergies

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

<b>Allergy</b>	e.g. wasps, pollen		
<b>Exposure</b>	e.g. airborne, ingested, physical contact		
<b>Reaction</b>	e.g. life-threatening, anaphylaxis, itchy eyes		
<b>Treatment</b>	e.g. EPI Pen, Claritin as needed		

### Dietary Restrictions

Lactose-intolerant  vegetarian: (e.g. lacto-ovo, vegan, no red meat) \_\_\_\_\_

Celiac  other (please describe) \_\_\_\_\_

### 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:

\_\_\_\_\_

**Method of Payment:** Please make cheques payable to C.Y.O. Camp Brébeuf for **\$300.00**

cheque / money order for \$\_\_\_\_\_ is enclosed

Visa  Mastercard Card Number: \_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_

Amount \$\_\_\_\_\_ Expiry Date: (month)\_\_\_\_\_ (year)\_\_\_\_\_

Cardholder Name: \_\_\_\_\_

Cardholder Signature: \_\_\_\_\_

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