☐ Alder Street ☐ Tony Rose ☐ Island Lake

Week: _____

Group: _____

Staff: _____

To be completed by staff

Camper Information Form

A. Participant Information

Name	Date of Birth	Attach Photo Here *(as required)*
Phone #		
Guardian's Name		
Guardians Phone #		

B. Emergency Contact Information*

In addition to Guardian listed above

Name	Phone #
Relationship	**Do they have permission to pick up?** YES / NO

C. Medication Information

Allergies & Medical Condition(s)
Behaviour Concerns

1. **Does your child/dependent require an auto-injector?** YES / NO *If 'Yes', how many will be available at camp?* 1 2
2. **Does your child/dependent require an asthma inhaler?** YES / NO *If 'Yes', how many will be available at camp?* 1 2
3. **Does your child/dependent require medication to be administered by staff?** YES / NO ***If 'Yes', please complete the back of this form***

Under what circumstances will emergency medication be administered? _____

_____

D. Additional Designated Pick-Up Information*

All persons picking up a child from camp must show Identification daily

	Name	Relationship	Phone #
1.			
2.			
3.			

E. Top Three things you would like us to know about your child*…

***Interests, hobbies, fears, etc.**

1.	
2.	
3.	

I, the undersigned, hereby:

- Certify that the information above is accurate and complete.
- Authorize Town of Orangeville staff to administer emergency medication(s) to my child/dependent applicable to the circumstances identified above.

_____ _____

Parent/Guardian Signature *Date*

Personal information is being collected pursuant to section 8 of the Municipal Act, 2001 and will be used to assess registration for the Town of Orangeville camps. If you have any questions about this collection, please call 519-940-9092.

Orangeville
Historic Charm Dynamic Future
Parks and Recreation

Medication Administration Form

A. Administration Information

Participant's Name	Location
Camp Name	Week Of

Name of Medication(s)	Time Medication is to be Administered	Amount/Dosage to be Administered	Storage Requirements

Medication Name* **to be completed by Camp Staff*

Monday	Time				
	Dosage				
	Admin. By (Name & Signature)				
	Witness By (Name & Signature)				
Tuesday	Time				
	Dosage				
	Admin. By (Name & Signature)				
	Witness By (Name & Signature)				
Wednesday	Time				
	Dosage				
	Admin. By (Name & Signature)				
	Witness By (Name & Signature)				
Thursday	Time				
	Dosage				
	Admin. By (Name & Signature)				
	Witness By (Name & Signature)				
Friday	Time				
	Dosage				
	Admin. By (Name & Signature)				
	Witness By (Name & Signature)				

I, the undersigned, hereby:

- Certify that the information above is accurate and complete.
- Authorize Town of Orangeville staff to administer the above mentioned medication(s) to my child/dependent applicable to the timeframes and dosages identified.

_____ _____

Parent/Guardian Signature *Date*

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