Rotary Club of Peterborough Kawartha

Adventure In Understanding – 2025 Canoe Experience Health Form

August 24, 2025 to August 29, 2025

CAMPER INFORMATION: (print clearly)

Last Name: _____ First Name: _____ Middle Initial: _____

Birthdate (yyyy/mm/dd): _____ Camper's Age on Aug 1, 2025: _____ Pronoun

Home Address: _____

City/Town: _____ Province/State: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Email # 1: _____ Email # 2: _____

PARENTS/GUARDIANS & EMERGENCY CONTACTS: (print clearly)

Marital Status of Camper's Parents/Guardians:
❑ Single ❑ Married ❑ Separated ❑ Widowed ❑ Divorced ❑Other _____
Legal Custody (be sure to include their contact information below):
❑Both Parents (live together) ❑Joint Custody (live apart) ❑Mother ❑Father ❑ Grandparents ❑Guardian
❑Foster Parents
Emergency Contact*:*
Please list in order who should be contacted in case of emergency – be sure to include parents/guardians

1st Contact: ❑Mr. ❑Mrs. ❑Ms. ❑Miss ❑Dr.
First & Last Name: _____
Relationship: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Address: _____
City: _____
Prov & PC: _____

2nd Contact: ❑Mr. ❑Mrs. ❑Ms. ❑Miss ❑Dr.
First & Last Name: _____
Relationship: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Address: _____
City: _____
Prov & PC: _____

3rd Contact: ❑Mr. ❑Mrs. ❑Ms. ❑Miss ❑Dr.
First & Last Name: _____
Relationship: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Address: _____
City: _____
Prov & PC: _____

4th Contact: ❑Mr. ❑Mrs. ❑Ms. ❑Miss ❑Dr.
First & Last Name: _____
Relationship: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Address: _____
City: _____
Prov & PC: _____

MORE INFORMATION ON PAGE 2

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HEALTH INFORMATION

Campers Health Card #: _____ **Version Code:** _____

Family Doctor: _____ Phone: _____

Address: _____ City: _____

A photo for emergency purposes will be taken on arrival day.

Permission for attending Doctor/Nurse to contact your Family Doctor if necessary? Yes ❑ No ❑

Immunization Dates: Tetanus: _____ Polio: _____ Pertussis: _____

(dd/mmm/yyyy) Diphtheria: _____ Hepatitis B: _____ Meningitis: _____

DIETARY RESTRICTIONS: ❑ Vegetarian ❑ Vegan ❑ Lactose Intolerant ❑ Gluten Free ❑ Other: _____

ALLERGIES: Be Specific, attach a separate page if necessary. If participant uses an Epipen, they must bring it on the trip. If you child has a life threatening allergy, you MUST fill out an "ANAPHLAXIS EMERGENCY PLAN FORM" in addition to this health form.

Indicate Type: Drug, Food, Environmental, Insect, Other	Allergen (please be specific)	Type & Severity of Reaction (Indicate if life-threatening)	Management / Treatment / Medication	Date of Last Reaction

ASTHMA: Does your child suffer from asthma? ❑ Yes ❑ No If yes, indicate severity? ❑ Mild ❑ Moderate ❑ Severe

What are the triggers for these attacks? _____

MEDICATIONS: Is the participant on any medication (prescription or homeopathic/naturopathic)? ❑ Yes ❑ No If yes, please list:

Medication	Amount	Frequency	Other Relevant Information

Please list any extra or relevant health information below:
