



**Rotary Club of Peterborough Kawartha**  
**Adventure In Understanding – 2026 Canoe Experience Health Form**  
 August 30, 2026 to September 04, 2026

**CAMPER INFORMATION: (print clearly)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Birthdate (yyyy/mm/dd): \_\_\_\_\_ Camper's Age on Aug 1, 2026: \_\_\_\_\_ Pronoun \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 City/Town: \_\_\_\_\_ Province/State: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Other: \_\_\_\_\_  
 Camper  
 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

1<sup>st</sup> Contact:  Mr.  Mrs.  Ms.  Miss  Dr.

2<sup>nd</sup> Contact:  Mr.  Mrs.  Ms.  Miss  Dr.

First & Last Name: \_\_\_\_\_

First & Last Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

City: \_\_\_\_\_

Prov & PC: \_\_\_\_\_

Prov & PC: \_\_\_\_\_

3<sup>rd</sup> Contact:  Mr.  Mrs.  Ms.  Miss  Dr.

4<sup>th</sup> Contact:  Mr.  Mrs.  Ms.  Miss  Dr.

First & Last Name: \_\_\_\_\_

First & Last Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

City: \_\_\_\_\_

Prov & PC: \_\_\_\_\_

Prov & PC: \_\_\_\_\_

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HEALTH INFORMATION

**Campers Health Card #:** \_\_\_\_\_ **Version Code:** \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

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

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

**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 "ANAPHYLAXIS 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: