Mountain View Summer Camp ~ Blind Camp 2025
Medical Form

Last Name		First Name	

Extend of Blindness	Details
☐ Totally Blind ☐ Legally Blind ☐ Sighted Guide	☐ Guide Dog ☐ Cane Travel ☐ Glasses
*Legally Blind and Visually Impaired: Central visual acuity for distance is no greater than 20/200 in the better eye with correction.	

Contact Lenses	Artificial Eye(s)
☐ Yes ☐ No ☐ Right ☐ Left	☐ Yes ☐ No ☐ Right ☐ Left
Care of contact lenses/artificial eye(s): Camper Cared for: ☐ Yes ☐ No Nurse Cared for: ☐ Yes ☐ No	If nurse cared for, please give details of removal, care, reinsertions, solutions and frequency below (use a separate sheet of paper if needed):

Medical and Health History Information ~ Required		
Provincial Care Card #	Medical Insurance Name	Policy/Group/ID/RX #'s
Date of last Tetanus Booster	Date of Polio Booster	CNIB#

List all medications currently taken ~ ask your pharmacist to provide medications in a Bubble Pack for Summer Camp (attach any additional meds on separate sheet of paper)

Medications taken	Dosage	Cared/Administered by		Initials
		Camper	Nurse	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

Is there a history of any of the following?			
	Yes	No	If yes, please explain
Infectious Disease(s)	☐	☐	
Asthma	☐	☐	
Thyroid Disease	☐	☐	
Eating Disorder	☐	☐	
Ear Infections	☐	☐	
Previous Surgeries	☐	☐	
Sinusitis	☐	☐	
Heart Disease	☐	☐	
Kidney Disease	☐	☐	
Colds/Sore throat	☐	☐	
Other	☐	☐	
Diabetes	☐	☐	Controlled by: Insulin ☐ Pill ☐ Diet ☐
Epilepsy	☐	☐	Grand Mal ☐ Petite Mal ☐
Date of last Seizure			Brief Description:

Allergies/Allergic Reactions (Check all the apply)						
	Yes	No	Severe	Moderate	Mild	***Bee/Insect Bites***
Penicillin	☐	☐	☐	☐	☐	☐ Yes ☐ No
Anesthetic	☐	☐	☐	☐	☐	Severe Moderate Mild
Other Meds	☐	☐	☐	☐	☐	☐ ☐ ☐
Food	☐	☐	☐	☐	☐	***Antidote for Insects/Bees***
Environment	☐	☐	☐	☐	☐	Benadryl Anakit Epikit
*Other	☐	☐	☐	☐	☐	☐ ☐ ☐
*Other ~ Explain:						Administered by:
						☐ Camper ☐ Nurse

Family Physician/Pediatrician ~ Must be filled in (Print)	
Physician/Pediatrician Name ~ Print Above	***Office Phone # ~ Print***
Address ~ Print on the line above	

I have examined the Camper herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities except as noted on his/her application form. Physician's signature _____

Ophthalmologist (Must be filled in)	
Name ~ Print Above	***Office Phone # ~ Print***
Address ~ Print on the line above	