YMCA DAY CAMP MEDICAL/BEHAVIORAL/LEARNING - 2024/2025

CAMPER'S NAME - FIRST / LAST	Age at the start of the camp:

Information provided on this form will be kept in confidence and will be disclosed on a need-to-know basis, to best support your child. Our camps include group based activities with a one councellor to 8-10 campers ratio based on age. We will not be able to safely support your child if we do not know their needs.

Does your child have any medical, behavioral or learning conditions that we should be aware of?	☐ YES ☐ NO
Does your child require 1:1 or small group support during the school year?	☐ YES ☐ NO
Has you child been diagnosed with Autism Spectrum Disorder?	☐ YES ☐ NO

If you answered yes, to any of the above, please provide some details: (diagnosis, support needed with activities of daily living, sensory sensitivities, communication challenges, challenges with understanding verbal instructions)

If your child is deemed to need extra support , we welcome you to provide a support person to the camper. They must be 18 years of age or older and must have a clean Criminal Reference Check , including Vulnerable Sector check PRIOR to the child attending the CAMP.

Name of the support worker attending the camp:	Email:	CELL #
		( )

Please answer the following questions and if you answered YES to any of the bellow, please give more details at the end of the form:

Is your child under any form of treatment for any physical or emotional illness, condition or injury?	yes	no
Will this treatment affect participation in camp activities?	yes	no
Are there any activities your child may not participate in because of medical /behavioral concerns?	yes	no
Does your child require medication for treatment of an illness, condition or injury?	yes	no
Will your child be carrying/requiring medication to be administered at camp?	yes	no
Does you child have any allergies?	yes	no
Does your child carry an EPI-PEN?	yes	no
In recent months, has there been any major illness, broken bones or operations?	yes	no
Does your child have any dietary restrictions?	yes	no

HEALTH HISTORY: Please indicate if your child experienced any of the following in the past year:

Seizures	yes	no
Vision Difficulty	yes	no
Hearing Difficulty	yes	no
Mobility Difficulty	yes	no
Diabetes	yes	no
Epilepsy	yes	no
Kidney Trouble	yes	no
Emotional Concerns	yes	no
Learning Concerns	yes	no
Behavioral Concerns	yes	no

If you answered yes, to any of the above, please provide some details: