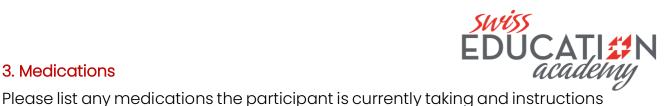


Health Questionnaire and Consent Form

| 1. Personal Infor | mation | | | | | |
|-------------------------------|----------------------------|--------------|----------|--------------------|--------|----------|
| Participant Nam | ne: | | | | | |
| Date of Birth (DI |)/MM/YYYY): / | // | | | | |
| Camp Dates: | | | | | | |
| Emergency Cor | ntact Person: ₋ | | | | | |
| Relationship to | Participant: | | | | | _ |
| Emergency Cor | ntact Phone N | umber: | | | | |
| Emergency Cor | ntact Email: | | | | | |
| 2. Medical Histo | ry | | | | | |
| Please provide | details of ar | ny relevant | medic | cal history to he | elp us | ensure |
| appropriate car | re. | | | | | |
| Does the partici | ipant have ar | ny pre-exist | ing me | dical conditions | 3. | |
| □Yes | | | | | | |
| □No | | | | | | |
| If yes, please sp | • | | | | | |
| Allergies | | | | | | |
| □ No known alle | ergies | | | | | |
| □ Yes, to (pleas | , , | | | | | |
| □ Mild □ Moder | ate □ Severe | | | | | |
| Chronic Illnesse | s/Conditions | (e.g., asthn | na, diak | oetes, epilepsy, e | etc.): | |
| □ None | | | | | | |
| | Yes, | | pled | ase | | specify: |
| Mental Health depression, ADF | | (optional | but re | ecommended, | e.g., | anxiety, |
| □None | | | | | | |
| | Yes, | | pled | ase | | specify: |





3. Medications

for administration. Is the participant currently taking any medications? ☐ Yes □ No If yes, please specify: Medication: ______ Frequency: _____ Is the participant able to take it without supervision: _____ Are camp staff allowed to administer medication if needed? ☐ Yes □ No Can the participant receive over-the-counter medications (e.g., pain relievers, antihistamines, etc.) for minor symptoms? □ Yes П Ио 4. Immunization Record Date of last tetanus booster: _____ (DD/MM/YYYY) 5. Dietary Restrictions Please specify any allergies, restrictions, or preferences. Food Allergies (e.g., nuts, dairy, gluten, etc.): □ None ☐ Yes, please specify: Dietary Preferences (e.g., vegetarian, vegan, halal, gluten-free): □ None ☐ Yes, please specify:





6. Physical Activity Limitations

| Are there any physical limitations or restrictions that affect the participant's |
|--|
| ability to join camp activities? |
| □ No |
| □ Yes, please specify: |
| Has the participant undergone any recent surgeries or hospitalizations that require care? No Yes, please specify: |
| 7. Consent for Treatment and Medication Administration |
| By signing below, I confirm that: |
| All information provided above is accurate and complete to the best of my knowledge. |
| - I give consent for camp staff to administer any medication listed above as per the instructions provided. |
| - I give consent for camp staff to administer over-the-counter medications as needed, unless indicated otherwise above. |
| In the event of a medical emergency, I authorize the camp staff to seek necessary medical treatment for the participant. This includes transportation to a medical facility and communication with healthcare providers. |
| I give consent for the camp to share relevant medical information with |
| healthcare professionals in case of need. |
| 8. Fitness for Participation |
| To the best of your knowledge, is the participant fit to participate in camp activities (hiking, swimming, group sports, etc.)? |
| □ Yes |
| □ No |
| If no, please explain: |





| Health Insurance Provider: |
|---|
| Policy Number: |
| 10. Signature and Consent |
| By signing below, I confirm that I have read and understood the contents of |
| this form and that I consent to the above conditions. |
| Participant Name: |
| Signature of Parent/Guardian (if participant is a minor): |
| |
| Date: |