135 King St W, Cobourg, ON K9A 2M7
Tel: (905) 372-1000 Fax: (416) 491-9898
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William Academy Summer/**Winter** Camp Form

Student Information and Family Information **(please fill out electronically)**

Legal Name	*(FAMILY)((Given)*	Gender		Nationality		
Passport Number		Hobby & Talent				
Date of Birth	*(YYYY/MM/DD)*	Email Address		WhatsApp Wechat		
Phone Number		Grade Completed		School Attended		
Father's name	*(FAMILY) (Given)*	Phone number		WhatsApp/ Wechat		
Date of Birth	*(YYYY/MM/DD)*	Email Address				
Mother's name	*(FAMILY)(Given)*	Phone number		WhatsApp/ Wechat		
Date of Birth	*(YYYY/MM/DD)*	Email Address				
Home Country Address	(Country)	(Postal Code)		Preferred Contact information/time		

School Registration & Agent Information

Have you study outside your home country?	Yes No Detail (if Yes):
How did you hear about William Academy Summer Camp	Newspaper Website Other: ____________________ Name ____________________ Tel ____________ Email ______________
Expected duration of the summer camp	1 week 2 weeks 3 weeks 4 weeks

Signature of Applicant/Parents ____________________ Date ____________________

William Academy is a registered and inspected school with the Ontario Ministry of Education (BSID # 889106)

William Academy Camp Health Form

Please ensure it is filled out completely & accurately. Campers cannot attend camp without a current health form on file prior to camp.

CAMPER INFORMATION: *(print clearly)*

Last Name:________________ First Name:________________ Middle Name:________________

Birthdate: (yyyy/mm/dd)________________ Camper's Age on July 1st:________________ Gender: Male Female

Household Address: ________________________________

City/Town:________________ Province/State:________________

Country:________________ Postal/Zip Code:________________ Home Phone#: ________________

PARENTS / GUARDIANS & EMERGENCY CONTACTS: *(print clearly)* *(attach separate sheet of paper if necessary)*

Legal Custody: **who has Custody and is Legally Responsible** for this camper (be sure to include their contact information below):

1st Contact:.
First & Last Name:________________
Relationship:________________
Home Phone:________________
Work Phone:________________
Cell:________________

2nd Contact:
First & Last Name:________________
Relationship:________________
Home Phone:________________
Work Phone:________________
Cell:________________

3rd Contact:
First & Last Name:________________
Relationship:________________
Home Phone:________________
Work Phone:________________
Cell:________________

Complete this section if you are a local student:

Camper's Health Card #:________________ Expiry Date:________________

Family Doctor:________________ Phone:________________

Family Dentist / Orthodontist: ________________ Phone:________________

Immunization Dates: Chicken Pox:________________ Hepatitis B:________________ Meningitis:________________

Diphtheria/Pertussis/Tetanus/Polio:________________ MMR (Measles/Mumps/Rubella):________________

ALLERGIES: Does your child have any allergies. Be specific, attach separate page if necessary.

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

DIETARY & RELIGIOUS RESTRICTIONS:

☐ Vegetarian ☐ Vegan ☐ Lactose Intolerant ☐ Gluten Free ☐ Other: ________________

☐ Islam Detail: ________________________________

ASTHMA/INHALER: Does your child have asthma? **No** **Yes**

If yes. What are the triggers for these attacks? ____

If your child will be carrying his/her puffer with them, please bring an extra non-expired puffer to be left in the Health Centre. If your child has used their puffer in the last year, they are required to have a puffer at camp.

MEDICATIONS AT CAMP: Will your child be taking any medications while at camp (prescription or homeopathic)?

If yes, list medication, dosage, schedule, route, and reason for medication: ____

____

MEDICATIONS AT HOME: Does your child regularly take any medications that will not be taken at camp?

____

OVER-THE-COUNTER MEDICINE AT CAMP:

Is there anything the camp needs to be aware of when giving any of the approved over-the-counter medications to your child?

____

HEALTH HISTORY: Has your child experienced or is currently experiencing any of the following conditions:

___ADD/ADHD
___Athlete's Foot
___Back / Neck Pain or Injury
___Bedwetting
___Behavioral Issues
___Blackouts / Fainting
___Bleeding Disorder
___Chest Pain
___Motion Sickness
___Concussion
___Constipation / Diarrhea
___Dental Braces / Caps / Bridges
___Diabetes
___Ear Infections / Hearing Problems
___Epilepsy / Seizures
___Fetal Alcohol Syndrome
___Headaches / Migraines
___Heart condition
___Visual Problems / Wears Glasses
___Homesickness
___Kidney Disease
___Learning Disabilities
___Menstrual Difficulties
___Mental Health Issues
___Nightmares / Terrors
___Nosebleeds
___Sinus infections
___Skin Problems
___Sleepwalking
___Speech Problems
___Stomach aches
___Sprains, Strains, or Fractures
___Tonsillitis
___Weight Concerns / Eating Disorder
___Covid-19
___Other, please explain:

1. I understand that all information collected will be used to diagnose, treat or maintain my child's physical or mental health and to assist in preventing disease or injury or to promote health. This information is considered to be confidential and will be shared amongst health care providers as needed; ie: Health Care Coordinator, Camp Nurse, Nurse's Assistant, Camp Physician, Walk in Clinic or Emergency Health Care Providers. This information will only be shared with the Camp Director and Camp staff on a need to know basis to ensure the physical and mental health of my child.
2. To the best of my knowledge, my child is in good health. I will notify the camp in writing prior to arrival if there is any change in my child's health, or he/she is exposed to any communicable disease within 3 weeks prior to arrival at camp.
3. In the case of a medical emergency, I understand that every effort will be made to contact parents or guardians. In the event I cannot be reached, I hereby give permission to the physician/nurse selected by the Camp Director to hospitalize, secure proper treatment, order injection, anesthesia or surgery for my child as named above.
4. I agree that the camp is not responsible for any expenses not covered by the insurance plan.
5. I will submit this health form to the camp prior to arrival.

Signature: ________________ ______________________ Date: ______________________

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