



155 Edward Street  
Aurora, ON, Canada L4G 1W3  
Phone: 888-273-7642  
Fax: 888-308-2267  
E-mail: info@rogerneilsonshockey.com  
www.rogerneilsonshockey.com

# MEDICAL FORM

Please print clearly and MAIL or FAX completed form.  
**REGISTRATION INFORMATION ON REVERSE SIDE**

FOR OFFICE USE  
Camper ID #

Roger Neilson's Hockey Camp recommends that campers who wear glasses bring a spare pair with them.  
If sending medication / inhalers or EpiPens, please ensure that all items are CLEARLY labeled with the camper's full name.

FIRST NAME	LAST NAME	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	HOME PHONE
FAMILY DOCTOR'S NAME		DOCTOR'S PHONE	LAST TETANUS SHOT MM / YY /

<b>ONTARIO RESIDENTS</b>	ONTARIO HEALTH CARD NUMBER	CODE IF APPLICABLE
--------------------------	----------------------------	--------------------

**NOTE:** Campers from outside of Ontario should arrange for 'out-of-province' or 'out-of-country' health insurance before arrival in Ontario. Local area hospitals require a credit card to cover any medical costs for patients who do not possess an Ontario Health Card number. As such, non-Ontario residents must provide the camp office with a valid credit card number for potential hospital billing. The hospital will provide official documentation so that these costs can be reclaimed through your insurance provider. **Please contact your insurance provider for details and limitations.**

<b>NON-ONTARIO RESIDENTS</b>	Non-Ontario residents <b>must</b> provide the Camp Office with a credit card number for medical emergencies.		
CARD TYPE	CARDHOLDER	CARD NUMBER	EXPIRY DATE MM / YY /

1. HAS PARTICIPANT BEEN TREATED FOR ANY SERIOUS ILLNESS - SUCH AS EPILEPSY, HEART DISEASE, ETC?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DETAIL:
2. DOES PARTICIPANT HAVE ANY ALLERGIES?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DETAIL:
<i>Does participant react to allergy by INGESTION or CONTACT?</i>	
<i>Does participant require an EPIPEN?</i> <input type="checkbox"/> YES <input type="checkbox"/> NO	
3. DOES PARTICIPANT SUFFER FROM ASTHMA?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DETAIL SEVERITY: <input type="checkbox"/> MILD <input type="checkbox"/> MEDIUM <input type="checkbox"/> SEVERE
IF YES, PLEASE LIST RELATED MEDICATION - INCLUDING INHALER TYPE / DOSAGE / FREQUENCY, ETC.	
4. WILL PARTICIPANT BE TAKING ANY <b>OTHER</b> PRESCRIPTION MEDICATION DURING CAMP?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DETAIL TYPE / DOSAGE / FREQUENCY, ETC. PLEASE ALSO LIST THE CONDITION(S) BEING TREATED:
5. HAS THE PARTICIPANT EVER HAD ANY SURGERIES OR SERIOUS INJURIES?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE PROVIDE DETAILS INCLUDING THE NAME(S) OF ATTENDING PHYSICIAN(S):
6. IS THERE ANYTHING ELSE RNHC AND/OR THE CAMP NURSE SHOULD KNOW?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE PROVIDE DETAILS. ATTACH ADDITIONAL SHEET IF NECESSARY:

We will always do everything possible to contact parents or emergency contacts in case of accident or illness. It may be necessary to get immediate medical attention for your child and it may not be possible to contact you prior to doing so. Your signature below grants us permission to get immediate medical help should it be necessary.

I HEREBY CONSENT to the admission of the above named child in case of an emergency to the nearest local hospital as may be available, and I grant permission to the Doctor in charge at such hospital to administer an anesthetic or to perform any other treatment deemed necessary. If the camper is from 'out-of-province' or 'out-of-country', I accept responsibility for all medical costs involved in the treatment of my child.

PARENT / GUARDIAN(S) NAME	SIGNATURE	DATE
---------------------------	-----------	------

**PLEASE COMPLETE REGISTRATION FORM ON THE REVERSE SIDE →**