

**PARKSIDE RANCH MEDICAL FORM (Session # \_\_\_\_\_)**

**Name** \_\_\_\_\_ **Birthdate** \_\_\_\_\_

**Recent Illnesses** \_\_\_\_\_  
(or any recent \_\_\_\_\_  
contact with a \_\_\_\_\_  
contagious disease - \_\_\_\_\_  
example: Chicken pox, mono, etc.)

**Allergies** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications** \_\_\_\_\_  
(Prescription & \_\_\_\_\_  
non-prescription) \_\_\_\_\_  
\_\_\_\_\_

**Activity Restrictions** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other Conditions** \_\_\_\_\_  
(head lice, parasites, etc.) \_\_\_\_\_  
\_\_\_\_\_

**Date of last Tetanus shot** \_\_\_\_\_ (If unknown and an injury occurs, one may be given at the discretion of the attending physician.)

**By signing below, I hereby give permission for medication/and or first aid treatment to be administered to my child by the designated First Aid Certified Person/and or Nurse.**

**Parent/Guardian Name (Please print clearly)** \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Medical Card #** \_\_\_\_\_ **Expiry Date** \_\_\_\_\_

**Home Phone #** \_\_\_\_\_ **Emergency Name and #** \_\_\_\_\_

**Please return this form to camp as soon as possible. Thank you.  
(Please remember to bring your medical card to camp)**

**PARKSIDE RANCH INC.**  
**1505 Alfred Desrochers**  
**Orford, QC J1X 6J4**

**NAME:**

**AGE:**

**MEDICARE NUMBER:**

**WEIGHT:**

(Child will be weighed at camp during registration)

**ALLERGIES:**

I allow Parkside Ranch to administer the following medications based on my child's weight:

Yes  No  Acetaminophen (i.e. Tylenol) \_\_\_\_\_ mgs every four hours as needed.

Yes  No  Acetylsalicylic Acid (i.e. Aspirin) \_\_\_\_\_ mgs every four hours as needed.

Yes  No  Diphenhydramine (i.e. Benadryl) \_\_\_\_\_ mgs every four hours as needed.

Yes  No  Dimenhydrinate (i.e. Gravol) \_\_\_\_\_ mgs every six hours as needed.

Yes  No  Ibuprofen (i.e. Advil, Motrin) \_\_\_\_\_ mgs every four hours as needed.

Yes  No  Loratadine (i.e. Claritin) \_\_\_\_\_ mgs as needed.

Yes  No  Bismuth subsalicylate (i.e. Pepto Bismol) \_\_\_\_\_ mgs as needed.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Nurse's Signature

\_\_\_\_\_  
Date