International Sivananda Yoga Vedanta Centres

Sivananda Yoga Kids Camp Health Registration Form

Blessed Parents*: This form is to be filled out by a physician. The physician`s signature must be obtained. In order for your child's application to be considered complete, this form must be submitted and along with it  a copy of  the child`s Health Card (for Canadian applicants), or Health Insurance/Travel Insurance documents (for International applicants).* ***The original Health Card or Health Insurance documents must be provided to Camp Staff upon registrations; failure to do so will result in non-admittance to the camp****.* We need these documents in order to ensure that your child has a safe and healthy stay at Camp.

Detailed Physical Health History

(Please circle and specify dates and treatment, if any)

Recurrent ear infections	YES	NO	______________________
Joint Problems	YES	NO	______________________
Seizures	YES	NO	______________________
Diabetes	YES	NO	______________________
Asthma	YES	NO	______________________
Fractures	YES	NO	______________________
Chicken pox/varicella	YES	NO	______________________
Measles	YES	NO	______________________
Mumps	YES	NO	______________________
Strep infection	YES	NO	______________________
Eczema	YES	NO	______________________
Asthma	YES	NO	______________________
Vision problem (incl. glasses)	YES	NO	______________________
Menstrual problems	YES	NO	______________________
Other communicable diseases	YES	NO	______________________

Any other recurring illness not noted above?

Any **specific** activity restrictions or mobility impairments affecting the practice of yoga and/or strenuous physical activity?

Detailed Mental Health History

(Please circle and specify dates and treatment, if any)

Depression	YES	NO	______________________
Anxiety	YES	NO	______________________
Attention-Deficit/Hyperactivity (ADHD)	YES	NO	______________________
Impulse Control Problems	YES	NO	______________________
Bipolar Disorder	YES	NO	______________________

Personality Disorder or Traits	YES	NO	____________________
Emotion Dysregulation	YES	NO	____________________
Self-Harm Behavior (i.e. cutting, burning)	YES	NO	____________________
Other Trauma-Related Symptoms	YES	NO	____________________
Aggression/History of Violence	YES	NO	____________________
Suicidality	YES	NO	____________________
Other Mental Health Concerns	YES	NO	____________________

If answered "YES" to any of the above, please specify details of diagnosis and treatment, including medications or talk therapy. Please outline the current status of the condition (in remission or current) Please ensure to include any details relevant to the safety of this child or others.

CURRENT MEDICATIONS

Please specify generic name, dosage, frequency and whether to be taken as needed (PRN) or regularly.

ALLERGIES

Does the child have any allergies to…
(Please circle and specify reaction type)

Insect stings	YES	NO	Specify:____________	**REACTION**:____________________
Penicillin	YES	NO	Specify:____________	**REACTION**:____________________
Medications	YES	NO	Specify:____________	**REACTION**:____________________
Food	YES	NO	Specify:____________	**REACTION**:____________________
Environmental	YES	NO	Specify:____________	**REACTION**:____________________

IMMUNIZATIONS

Please specify if received, details, and dates. Requirement immunizations must be determined locally.

Diphtheria, Tetanus, Polio, Pertussis, Hib

DTaP-IPV-Hib Series	YES	NO	____________________
Tdap-IPV	YES	NO	____________________
Tdap	YES	NO	____________________
Td	YES	NO	____________________

Pneumonia

Pneu-C-13	YES	NO	______________________

Measles, Mumps, Rubella

MMR Series	YES	NO	______________________

Chickenpox

Varicella	YES	NO	______________________

Others

Hepatitis A	YES	NO	______________________
Hepatitis B	YES	NO	______________________
Meningitis	YES	NO	______________________
HPV	YES	NO	______________________
Typhoid	YES	NO	______________________
Rabies	YES	NO	______________________
Japanese Encephalitis	YES	NO	______________________
Others:	YES	NO	______________________

MEDICAL EXAMINATION

The purpose of this examination is to ensure fitness to engage in strenuous activities, including yoga practice. This examination should be ***performed within 6 months of the expected date of arrival at Camp.***

General: ____
Height: _______________Weight:__________BP:____________HR:________RR:_____
Skin: ____
Head, eyes, ears, throat & neck (HEENT): ____________________________________
Dental: ____
Cardiovascular system: ____
Respiratory system: ____
Abdomen: ____
Posture (back and spine): ____

PHYSICIAN AUTHORIZATION

By signing below, I confirm that this health history is accurate and complete, to the best of my knowledge. The person herein described has the permission and ability to safely engage in all camp activities, except as noted by me above.

Physician Signature:___________________________________ Date:_________________
Physician Name:_______________________________________
Physician Address/Clinic Stamp:________________________
Physician Fax Number:_________________________________
Physician Phone Number: _____________________________

International Sivananda Yoga Vedanta Centres

AUTHORIZATION TO RELEASE INFORMATION

We are requesting a release of information to communicate with your child's health care providers, including mental health providers (such as therapists or counsellors), to ensure that we are able to access the information about your child's health that we need to make sure that they are safe and healthy at camp. We will treat this information with respect.

Child's Full Legal Name: ____________________________________Date of Birth:_________________

I/we, the undersigned

____

{your full names}

Authorize the release of the following information:
________________all medical and mental health information for {CHILD'S NAME}________________

From

_{family doctor name, phone, fax number and address}___________________________________
_{therapist/counsellor name, phone, fax number and address}_____________________________
_{specialist name, phone, fax number and address}___________________________________

To
Kids/Teen Camp Director, Sivananda Yoga Camp, International Sivananda Yoga Vedanta Centres
673 Eighth Avenue, Val Morin, Quebec, J0T 2R0

For the purpose of:
Ensuring child's health & safety while they are under the care of the Camp, particularly in the event of a medical emergency or mental health crisis

Signatures
I/we authorize my health care and mental health care providers to disclose the child's health information described above to the (s) identified above. I/we understand why I/we have been asked to disclose my health information and I/we am/are aware of the risks and benefits of consenting or refusing to consent. I/we understand that this release of information will remain in effect for the duration of my child's participation in the Kids/Teen Yoga Camp.

Parent/Legal Guardian (1):_________________________________ Date:_________________

Parent/Legal Guardian (2)):_________________________________ Date:_________________

Child/Teen):_________________________________ Date:_________________

Witness):_________________________________ Date:_________________

Parent(s)/Child Authorization

I also certify that the health history outlined by the physician is accurate and complete, to the best of my knowledge. In the event that I/we cannot be reached in an EMERGENCY, I hereby give permission to the physician or hospital selected by the Camp staff to secure treatment necessary for my child/ward. (Please note that every effort will be made to contact a family member or the emergency contact provided; however, we ask for this authorization to avoid any unnecessary treatment delays in urgent situations). Treatment may include anything recommended by the health care provider consulted; examples include injections, medications, casting, transfusions, anesthesia or surgery as necessary.

Parent/Legal Guardian (1):__________________________________ Date:_________________

Parent/Legal Guardian (2)):__________________________________ Date:_________________

Child/Teen):__________________________________ Date:_________________

Witness):__________________________________ Date:_________________