



CAMP DE VACANCES ET RÉPITS

DETAILED HEALTH INFORMATION

PARTICIPANT			
First name		Last	
Date of birth		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Health ins. card		Exp.	
Does the participant have medical	<input type="checkbox"/> Private	<input type="checkbox"/> RAMQ	<input type="checkbox"/> Other(s) :
Tetanus vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:	
The participant suffers from following conditions/diseases :			
<input type="checkbox"/> Asthma <input type="checkbox"/> Indigestion <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Bulimia <input type="checkbox"/> Constipation <input type="checkbox"/> Heart trouble <input type="checkbox"/> Urinary disorders <input type="checkbox"/> Aids / HIV <input type="checkbox"/> Hepatitis <input type="checkbox"/> Skin problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Controlled <input type="checkbox"/> Non-controlled (<i>Provide the medical report and the latest crisis</i>)			
Does participant suffer from incontinence? <input type="checkbox"/> yes, daytime <input type="checkbox"/> yes, nighttime <input type="checkbox"/> No			
ALLERGIES	<input type="checkbox"/> No	<input type="checkbox"/> Yes, please specify:	
FOOD ALLERGIES	<input type="checkbox"/> No	<input type="checkbox"/> Yes, please specify:	
Have an EpiPen	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other allergies:	
Does participant possess a hearing aid?	<input type="checkbox"/> Cochlear implant	<input type="checkbox"/> Hearing aid	<input type="checkbox"/> Other:
Communicates in:	<input type="checkbox"/> LSQ	<input type="checkbox"/> French	<input type="checkbox"/> ASL <input type="checkbox"/> English <input type="checkbox"/> Pictograms
Names of other diseases or handicaps			
Medical history (please include the detailed diagnostic related to the disease or handicap)			
Other important information			
Does participant have a special risk of dehydration, heat stroke or any infection?			
<input type="checkbox"/> No <input type="checkbox"/> Yes, please specify when:			



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INDEPENDENCE / AUTONOMY

Dressing: Alone with help, specify: not able
Washing: Alone with help, specify: not able
Going to washroom: Alone with help, specify: reminder
Orientation: Alone with help, specify: not able
Moving: Alone with help, specify: not able
Uses wheelchair or other walking support: Yes, specify:

EATING HABITS / RESTRICTIONS

Eats: Alone with help, specify: _____
Drinks: Alone with help, specify: _____
Dietary restrictions or intolerance: No Yes, specify: _____
Food allergies: _____
Food presentation: Normal Chopped Pureed Liquid

Type of behavior and level of understanding of instructions

Does the participant have these types of behaviours

Aggressive towards him/herself Runs away Isolates him/herself Anxiety
 Aggressive towards others Hyperactivity Autistic gestures Opposition

Which elements or events trigger disruption for the participant and their control

Important routine to follow with the participant

Date

Signature



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