YORK
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CIFAL YORK

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Tech Innovators March Break 2026 Camp: Exploring the Future

Medical Information & Medication Form

Camp Dates: 08/10/2026 - 08/14/2026

Camp Location: York University, Schulich School Basement, Rm. N004, Schulich School of Business.

Please complete this form to inform us of any medical conditions, ongoing health concerns, or medications your child requires while attending the camp. All information will be kept confidential and used only to ensure your child's health and safety.

Participant's Information:

- Full Name: _____
- Date of Birth: ___ / ___ / ____ (MM / DD /YYY)
- Provincial Health Card Number: _____ (If applicable)
- Date(s) attending the camp: _____

Guardian Information:

- Guardian Name: _____
- Relationship to Child: _____
- Primary Phone Number: _____
- Emergency Contact Phone Number (if different):
  _____
- Email Address: _____

Medical Conditions:

- Does your child have any ongoing medical conditions, illnesses, or health concerns that the camp should be aware of (e.g., asthma, diabetes, epilepsy, allergies - *please also complete the separate Food Allergy Form if applicable*, etc.)?
  - □ Yes
  - □ No
- If YES, please describe the condition(s) and provide any relevant details:
  _____
  _____
  _____
  _____
  _____
  _____
- Please describe any limitations or restrictions on your child's activities due to their medical condition(s):
  _____
  _____
  _____

Medication Information:

- Does your child need to take any medication (prescription or over-the-counter) while at camp?
    - □ Yes
    - □ No
- If YES, please list all medications below:

Medication Name	**Dosage**	**How & When to Administer (e.g., with food, specific times)**	**Reason for Medication**	**Potential Side Effects**

- Please provide medications in their original containers with clear labeling including the child's name, medication name, dosage, and frequency.
- All medications will be kept by the designated camp staff and administered as instructed. Please do not pack medication in your child's लिंग suitcase or backpack.
- If your child requires an emergency medication (e.g., asthma inhaler, EpiPen - *if not already noted on the Food Allergy Form*), please specify where it will be kept (e.g., with the child, with the camp medic).
- Are there any medications your child is allergic to?
    - □ Yes
    - □ No
- If YES, please list them: _____

Other Medical Information:

- Does your child use any medical devices (e.g., inhaler, nebulizer, glucose meter)?
  - □ Yes
  - □ No
- If YES, please describe and provide instructions for use:
  _____
  _____
  _____
- Are there any other medical considerations or care instructions that the camp staff should be aware of?
  _____
  _____
  _____

Healthcare Provider Information:

- Family Physician Name: _____
- Phone Number: _____
- Specialist Name (if applicable): _____
- Phone Number: _____
- Type of Specialist: _____

Consent and Signature:

I have provided accurate and complete information regarding my child's medical conditions and medications. I authorize the designated camp staff to administer medications as instructed and to seek emergency medical treatment for my child if necessary. I understand that I will be contacted in case of a medical emergency.

Guardian Signature: _____

Printed Guardian Name: _____

Date: ___ / ___ / ____ (MM / DD /YYYY)