



# CAMP DE VACANCES ET RÉPITS

## DETAILED HEALTH INFORMATION

PARTICIPANT			
First name		Last	
Date of birth		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Health insurance		Expirat	
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"/> No <input type="checkbox"/> Yes (mandatory)			
ALLERGIES	<input type="checkbox"/> No	<input type="checkbox"/> Yes, please specify:	
ALLERGIES food	<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
<b>Names of other diseases or handicaps</b>			
Medical history (please include the detailed diagnostic related to the disease or handicap)			
<b>Other important information</b>			
Does participant have a special risk of dehydration, heat stroke or any infection?			
<input type="checkbox"/> No <input type="checkbox"/> Yes, please specify when:			



À L'ÉTAT *naturel*

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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:  Not able  
Drinks:  Alone  with help, specify:  Not able  
Dietary restrictions or intolerance:  No  Yes, specify:  
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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