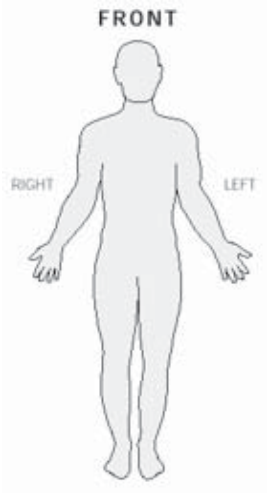
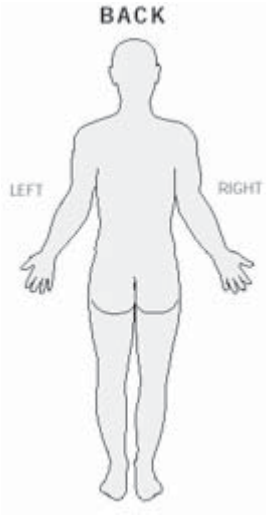
CAMPER INITIAL ASSESSMENT FORM

This form is to be completed by all camping families **prior** to arrival at camp. Please complete this document no more than **TWO (2)** Day prior to the session start date. Indicate all concerns both in writing and by marking the diagrams. The form will be reviewed with the Health Care Team onsite and by Camp Counsellors.

Camper Name_____
Disability_____
Age _____ **Sex** _____**Camp** _____ **Date** _____

Injury or Areas of Concern/Sensitivity - Description (i.e.-location, size, colour, etc):





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Signature – Parent/Guardian **Print Name** **Date**

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Staff Only Below this line

HCT Follow-up:_____

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_____ _____ _____ _____

HCT Member Signature Counsellor Signature