

Rock Lake United Church Camp
Medical Treatment Record

Name of patient: _____ Camper Staff:

B C Health Care Card No _____

Treatment start date: _____ Treatment end date: _____

Condition on arrival at camp: _____

Reason for consulting camp nurse: _____

Treatments while at camp: _____

Name of consultant doctor, if any: _____ Date: _____

Hospital treatment, if any (e.g., X-rays): _____

Additional Notes: _____

Parent/guardian notified: _____ Date & Time: _____

Signature of Camp Nurse/First Aid Attendant: _____

The use, retention, and disclosure of personal information collected from this form is done in compliance with privacy legislation including, but not limited to, the Personal Information Protection and Electronic Documents Act (2000, c.5).