

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).