**IMPORTANT IMPORTANT IMPORTANT!!!**

***SCHOOL– Yr ?***

*Term:* ***?*** *Week:* ***?*** *Dates:* ***?/?*** *to* ***?/?***

*School Activity Group Name:* ***(ie A/1, B/2, C/3, D/4)***

* **This form is to be faxed (49823298) or emailed to CFOEC no later than the Monday one week prior to your camp.**
* One synopsis to be completed for each activity group. (eg 3 groups in your school = 3 medical synopsis sheets)
* Synopsis MUST include **ALL students and adults** regardless if they have a medical condition or not
* Synopsis MUST include Individual Action Plans for students who have them – especially those with an Epipen, Diabetes, Asthma, Allergies, etc.

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| --- | --- | --- | --- | --- | --- |
|  | **NAME** | **MEDICAL CONDITION, SEVERITY, MEDICATION, DIETARY REQUIREMENT, EMERGENCY CONTACT** | **PHYSICAL/LEARNING CONSTRAINTS**  (ie ASD, II, broken bones) | **SWIMMING ABILITY**  **Beginner / Intermediate / Advanced** | **ACTION PLAN ATTACHED** |
| **Students** | | | | | |
| **1** |  |  |  |  |  |
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| **23** |  |  |  |  |  |
| **24** |  |  |  |  |  |
| **Adults** | | | | | |
| **1** |  |  |  |  |  |
| **2** |  |  |  |  |  |
| **3** |  |  |  |  |  |