

Camper Name: _____ Session: _____ (Office Use Only)

Health History and Examination Form

Camper Birth Date: _____ Age at Camp: _____ Gender: Male Female

Custodial Parent/Guardian: _____ Phone: _____

Home Address: _____
Street Address City State Zip

Work Phone: _____ Cell Phone or Pager: _____

Second Parent / Guardian / Emergency Contact (Please circle one): _____

Home Address: _____ Phone: _____
Street Address City/State/Zip

Work Phone: _____ Cell Phone or Pager: _____

If not available in an emergency, notify: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone or Pager: _____

Insurance Information

Is the camper covered by family medical/hospital insurance? Yes No

If yes, indicate carrier or plan name: _____ Group#: _____

Carrier Address: _____

Name of Insured: _____ Relationship to Camper: _____

Social Security Number of policy holder or insurance ID Number: _____

Medications

List all over-the-counter, non-prescription and prescription drugs taken regularly by the camper. In the original container, pack enough medication to last the entire stay at camp. Make sure that all prescription drugs are in the original container that includes the physician name, medication name and dosage/administration instructions. **Put all medications into a ziploc bag labeled with the camper's name and take it to the check-in or the bus stop.**

The camper takes medications on a regular basis: Yes No

This camper takes the following medications:

Medication: _____ Reason for taking: _____

Dosage/Administration Instructions: _____

Medication: _____ Reason for taking: _____

Dosage/Administration Instructions: _____

Medication: _____ Reason for taking: _____

Dosage/Administration Instructions: _____

Has the camper had any recent illness, injury or infectious disease? Yes No

If yes, please explain: _____

Important - The information below must be completed for attendance*

I hereby give permission to the medical personnel selected by the Camp Director to provide routine health care; to administer medications; to order X-rays; routine tests; treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physicians selected by the Camp Director to secure and administer treatment, including hospitalization, for the person named above. YMCA Camp Pinewood will make every attempt to notify you before making a doctor's appointment or an emergency room visit for your child while they are in our care. All minor medical needs will be cared for by the on-site Health Director without notification of parents.

Parent/Guardian Signature: _____ Date: _____

**If for religious reason you cannot sign this, contact the camp for a legal waiver, which must be signed for attendance.*

Health History

_____ Chicken Pox	_____ Ear Infections	_____ Migraines	_____ Mononucleosis
_____ Measles	_____ Rheumatic Fever	_____ Nosebleeds	_____ Surgeries
_____ Convulsions	_____ German Measles	_____ Braces	_____ Dizziness
_____ Mumps	_____ Diabetes	_____ Heart Murmur	_____ Seizures
_____ Asthma	_____ Behavior	_____ Contact Lenses	_____ Eating Disorders

Other health concerns or details of any of the above: _____

Immunization History (Please list dates as accurately as possible)

_____ DPT Series	_____ Booster	_____ Tetanus Booster	_____ Hepatitis B
_____ Polio OPV (Sabin)	_____ Booster	_____ Tuberculin Test	_____ MMR
_____ Other (please list) _____			

Health Care Examination/Recommendations by Licensed Medical Personnel

The Health Care Examination section must be completed by a licensed physician before attending camp. If the camper has had a general examination for any other reason within the past 12 months, a copy of that health record can be attached.

Camper Name: _____ I examined the individual on _____ (date)

The applicant is under the care of a physician for the following conditions: _____

Height _____ Weight _____ Blood Pressure _____ Eyes _____ Glasses _____ Ears _____ Nose _____

Throat _____ Teeth _____ Skin _____ Posture/Spine _____ Heart _____ Lungs _____ Hernia _____

Abdomen _____ Extremities _____

Females: Menstrual History Normal _____ Special Considerations _____

Recommendations and Restrictions at Camp

Treatment to be continued at camp: _____

Medically-prescribed meal plan/dietary restrictions? _____

Medication Allergies	Describe reaction and management/treatment
_____	_____
_____	_____

Food Allergies/Dietary Restrictions	Describe reaction and management/treatment
_____	_____
_____	_____

Other Allergies	Describe reaction and management/treatment
_____	_____
_____	_____

Restrictions/Limitation of camp activities? (e.g. what cannot be done, what adaptations are necessary, etc.)

I have examined the person described and have reviewed his/her health history. It is my opinion the he/she is physically able to engage in camp activities, except as noted.

Physician Signature: _____ Date: _____