SUMMER AT THE YMCA—2019

Health History Form

This form must be filled out completely, signed by the camper's parent/guardian, and returned with requested documentation to the camp office or YMCA Branch by **JUNE 1.**
Email the completed form to the listed contact.

Camper's Name _____ **Birthday** _____/_____/_____ **Age**____

Mailing Address_____ **Grade in Fall 2019** _____

_____ **Gender Male Female**

Camper Lives With _____ **Relationship To Camper** _____

Primary Guardian's Name & Email _____

Primary Guardian's Phone # _____ Alternate Phone # _____

Secondary Guardian's Name & Email _____

Secondary Guardian's Phone # _____ Alternate Phone # _____

Emergency Contact Name _____ Relation to Camper_____

Emergency Contact Phone # _____ Alternate Phone # _____

CAMPER MEDICAL INFORMATION:

Name of Family Physician _____ Phone # _____

Name of Family Dentist _____ Phone # _____

IMMUNIZATION HISTORY:

☐ I hereby verify that my child is current on all immunizations required for school. Please initial _____

If not, please explain _____

Date of last Tetanus shot _____/_____/_____

GENERAL HEALTH HISTORY

Please check if any of the below apply.

- ☐ Recent injury, illness, or infectious disease
- ☐ Chronic or recurring illness/condition
- ☐ Ever had surgery
- ☐ Ever had seizures
- ☐ Skin conditions
- ☐ Diabetes
- ☐ Asthma
- ☐ Sleepwalking or night terrors
- ☐ History of bedwetting
- ☐ Wakes in night to use restroom
- ☐ History of being afraid of the dark
- ☐ History of noise while sleeping (snores, talks, etc)
- ☐ Frequent ear infections
- ☐ Heart defect/disease
- ☐ Blood disorder (hepatitis, HIV, clotting, etc)
- ☐ Nosebleeds
- ☐ Hypertension
- ☐ Mononucleosis
- ☐ Chicken Pox
- ☐ Measles/German Measles
- ☐ Mumps
- ☐ Contact lenses
- ☐ Braces, retainers, or other dental items
- ☐ Ever had professional help for behavioral or emotional difficulties
- ☐ Mental health hospitalization
- ☐ Attention Deficit Hyperactivity Disorder
- ☐ Anxiety
- ☐ Tic Disorder
- ☐ Tourette's Syndrome
- ☐ Autism Spectrum Disorder
- ☐ Behavior Disorder
- ☐ Depression
- ☐ Obsessive Compulsive Disorder
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ Pervasive Development Disorder
- ☐ Oppositional Defiant Disorder
- ☐ Learning Disability
- ☐ Have any restrictions to activities (what cannot be done/adaptations/limitations necessary)
- ☐ Dietary Restrictions (vegetarian, vegan, gluten, lactose intolerant, etc)
- ☐ Additional concerns Camp should be aware of (behavior, physical, emotional health, etc)

Please explain all checked items _____

_____

_____

_____

ALLERGIES

Please check if any of the below apply. If checked, please state if the allergy is mild, moderate, or severe AND if the allergy is contact or airborne.

- ☐ Horses
- ☐ Insect Stings
- ☐ Penicillin
- ☐ Environmental (Pollen, trees, mold, etc)
- ☐ Food _____
- ☐ Peanut/Tree Nut
- ☐ Other _____

Severity of reaction and action plan for your camper _____

_____

MEDICATIONS Please list **ALL** medications (including over-the-counter and non-prescription) that are taken routinely by the camper. For Camp Abe Lincoln Campers, please bring enough medication to last for the whole week. **ALL** medication must be in its original packaging that identifies prescribing physician (if prescribed).

- ☐ **This camper does not take any medication**
- ☐ **This camper takes routine medication (including vitamins) as follows:**

Medication	Dosage	Times Taken	Reasons for taking

AUTHORIZED PICK UP LIST (INCLUDE PARENTS IF AUTHORIZED TO PICK UP)

Name _____ Relationship:_____

Phone # _____ Alternate Phone # _____

Name _____ Relationship:_____

Phone # _____ Alternate Phone # _____

Name _____ Relationship:_____

Phone # _____ Alternate Phone # _____

Name _____ Relationship:_____

Phone # _____ Alternate Phone # _____

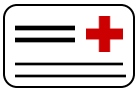
Name _____ Relationship:_____

Phone # _____ Alternate Phone # _____

THE FOLLOWING SECTION SHOULD BE FILLED OUT FOR
CAMP ABE LINCOLN CAMPERS ONLY:

The following medications may be dispensed by our Health Administrators. Please cross out any medications which your camper **SHOULD NOT** be given:

Acetaminophen (Tylenol)	Day/Nigh Cold & Flu	Tums	Omeprazole Acid Reducer	Rubbing Alcohol
Kid's Liquid or Chewable Acetaminophen	Cough Drops	Pepto	Chewable Stomach Relief	Aloe Vera Lotion or Spray
Ibuprofen	Cough Syrup	Imodium A-D	Chewable Antacid	Sterile Eye Drops
Kid's Liquid or Chewable Ibuprofen	Nasal Decongestant (Phenylephrine HCL)	Milk of Magnesia	ChlorTabs (Allergy Relief)	Vapor Rub
Latex Bandaids	Diphenhydramine HCL (Benadryl)	Hydrocortisone Cream	Loratadine (Allergy Relief)	Epsom Salt
Anti-Itch Cream or Spray	Suphedrine HCL	A & D Skin Protectant	Kid's Liquid Allergy Relief	Hydrogen Peroxide



CAMPER HEALTH INSURANCE INFORMATION:

A photocopy of **BOTH** sides of your health insurance, Medicaid, or Title XIX card must be attached to this form. If you do not have health insurance, please initial here: _____

FOR CAMP USE ONLY

Is all the information current? YES ☐ NO ☐ Explain _____

Does the camper have medications? NO ☐ YES Logged on health book _____

Does the camper have allergies? NO ☐ YES ☐ Informed Kitchen _____Counselors_____

Head checked and cleared? YES ☐ Date _____

THE FOLLOWING SECTION SHOULD BE FILLED OUT FOR
ALL SCOTT COUNTY FAMILY Y CAMPERS:

ADDITIONAL CAMPER INFORMATION Please provide any additional information that you feel our staff should know to make this camp experience successful for your child.

_____

_____

_____

_____

_____

_____

PARENT'S AUTHORIZATION

This health history is correct and accurately reflects the health status of (camper to whom it pertains) _____. S/he has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child.

I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

The Scott County Family Y (hereinafter referred to as "Y") is not obligated to furnish any insurance under the Y program referred to below although it may do so without any obligation as to the adequacy of any insurance it may furnish. I, the parent/legal guardian of the program participant, agree that they and all individuals participating in Y programs in any capacity, will not be liable for any causes of actions, claims and injuries arising out of the participation of the applicant in the Y programs, and hereby release all said individuals from such claims and liabilities. The undersigned acknowledges that in all camp activities there are certain risks of physical injuries and all participants participate at their own risk. I, as parent/legal guardian of a program participant under the age of 18, consent to the participation of the applicant in Y programs listed on the registration from under the above mentioned conditions.

I DO _____ DO NOT _____ give consent to be photographed, videotaped and/or filmed while participating in any YMCA activities and for the resulting photos, etc. to be used by the YMCA for educational and promotional purposes. I have read and understand above.

_____

Primary Guardian Signature Date