Camper Health History Form 2018

Camper Name:_____

Male Female Birth Date:_____ Age at Camp:_____

Home Adress:_____ _____

Street City State Zip

2 Best Phone Numbers:_____ _____

Authorized Pickup/Emergency Contact

Name	Mother/Father	Best Phone Number	Second Phone Number
Name	Relation	Best Phone Number	Second Phone Number
Name	Relation	Best Phone Number	Second Phone Number

Camper Information

- ☐ Camper has never been away from home overnight.
- ☐ Camper gets homesick.
- ☐ Camper cannot go into the water for medical reasons
- ☐ Camper must wear a lifejacket
- ☐ Camper wets the bed at night
- ☐ Camper needs reminders to use the bathroom
- ☐ Camper has run away before
- ☐ Camper needs encouragement to stay on task

Camper socializes: **well**_____ **average**_____ **poorly**_____

Camper follows directions: **well**_____ **occasionally**_____ **never**_____

What would you like your camper to accomplish at camp?

_____

Camper has allergies:_____

Camper has food allergies or dietary restrictions: _____

Counselor Information

Any special needs, medical restrictions, activities to avoid, or other information your camper's counselor should be aware of:

_____

_____

_____

_____

_____

_____

_____

Parent/Guardian Authorization for Health Care

The Akron Area YMCA and YMCA, YMCA Camp Y-Noah, will herein be referred to as 'Camp.'

The camper named has permission to participate in all camp activities, except as noted by me and/or the examining physician. I agree to waive any claims against Camp for injuries or damages that may result from participation in programs. I give permission to the physician selected by the Camp to provide routine health care, first aid, medication or treatment as determined by medical personnel. **IN CASE OF EMERGENCY** or medical care beyond the scope of camp facilities, I understand that every effort to notify listed contacts will be made. I authorize Camp personnel to act on our behalf and secure emergency medical treatment and grant permission to the attending physician to secure proper treatment for the named camper. **PERMISSION TO DISTRIBUTE**: I authorize Camp personnel to administer medication(s) to the named camper. I understand that all prescribed medications brought to camp *MUST* be in the pharmacy labeled container with camper's name, dosage, health care providers name and phone number. Camp personnel will distribute per the licensed physician instructions. I give permission for the leadership staff of Camp to use their discretion on sharing this information with appropriate staff. I give my consent for Camp to provide transportation related to Camp activities. I authorize Camp to take and use any photographs, comments, and videos of my child for promotional purposes. All information pertaining to the named camper is complete and accurate to the best of my knowledge.

Parent/Guardian Signature:_____ **Date:**_____

☐ Please check this box if you do not give permission to treat.

Camper Health History Form 2018

Camper Name:_____

Birth Date:_____

General Health History

Check "Yes" or "No" for each statement. Explain "Yes" answers. Has/does the camper:

	YES	NO
1. Been hospitalized in the last 12 months?		
2. Had Surgery in the last 12 months?		
3. Have recurrent/chronic illnesses?		
4. Had a recent infectious disease?		
5. Had a recent injury?		
6. Have diabetes?		
7. Had seizures in the last 12 months?		
8. Had headaches in the last 12 months?		
9. Had fainting/dizziness in the last 12 months?		
10. Ever had back/joint pain?		
11. Wear glass, contacts, protective eyewear?		
12. Had asthma/wheezing/shortness of breath?		
13. Passed out/had chest pain during exercise?		
14. Current medications, prescribed and over-the-counter?		
15. Had mononucleosis in last 12 months?		
16. If female, have problems with periods?		
17. Have problems falling asleep/sleepwalking?		
18. Have problems with diarrhea/constipation?		
19. Traveled outside the country past 9 months?		
20. Ever been treated for ADD or AD/HD?		
21. Ever been treated for emotional or behavioral difficulties or an eating disorder?		
22. During the past 12 months, seen a professional to address mental/emotional health concerns?		
23. Does the camper have an individual education plan (IEP)?		
24. Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, etc)		
25. Any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or consideration while at camp?		

Please explain any "YES" answers noting the number of the questions. For #18 please name countries visited & dates of travel. For #22 please attach a copy.

Health-Care Providers

Name of camper's primary doctor(s):_____ **Phone: (___)**_____

Name of dentist(s):_____ **Phone: (___)**_____

Name of orthodontist(s):_____ **Phone: (___)**_____

Medical Insurance Information

This camper is covered by family medical/hospital insurance: (circle one) Yes No

Include a copy of your insurance card if applicable; Copy both sides of the card so information is readable.

Insurance Company:_____ Policy Number:_____

Subscriber:_____ Insurance Company Phone Number: (_____)_____

Immunization History

☐ All my camper's immunizations required for school are up to date. Date (month/year) of last tetanus shot ___/___

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature:_____ Date:_____

Medications

The following non-prescription medications are commonly stocked in the camp health lodge and used on an <u>as needed basis</u> to manage illness and injury. **Cross out those items the camper should <u>not</u> be given.**

Acetaminophen (Tylenol)	Ibuprofen (Advil, Motrin)	Phenylephrine (Sudafed PE)	
Guaifenesin (Mucinex)	Aloe	Diphenhydramine (Benadryl)	Generic cough drops
Chloraseptic (Sore throat spray)	Calamine Lotion	Bismuth subsalicylate (Pepto-Bismol)	Laxatives (Miralax)
Hydrocortisone 1% cream	Topical antibiotic cream	Calcium Carbonate (Tums)	Dextromethorphan(cough syrup)