YMCA Camping Services
HEALTH FORM

PARTICIPANT INFORMATION

________________________	______________________________	_____/_____/_____	_____
First Name	Last Name	Birthdate	M/F

________________________________	____________	_____	________	(______)__________________
Home Address	City	State	Zip	Home Phone #

____________________________	(______)____________	(______)____________	(______)____________
Parent/Guardian 1 Name	Home Phone #	Work Phone #	Cell Phone #
____________________________	(______)____________	(______)____________	(______)____________
Parent/Guardian 2 Name	Home Phone #	Work Phone #	Cell Phone #

Our goal is to provide a complete camping experience for all. To accomplish this goal, we ask all of our campers and staff to inform us of any disabilities, impairments or restrictions. We recommend that all campers and staff have a physical completed within 12 months of attending camp. We use this information to provide staffing levels and to insure that potential accommodations are available.

Please note any impairments, disabilities or restrictions :____

·Please indicate any history of the following injuries or illnesses:

__ Chicken Pox	__ Bee Sting Allergy	__ Ankle Injury
__ Frequent Ear Infections	__ Diabetes	__ Knee Injury
__ Asthma	__ Back Injury	__ Heart Problem(s)
__ Convulsions	___Other_______________________________	

· Any allergies or drug sensitivities? ___Yes ___No If yes, please describe:___________________________

____

· Please record any significant medical or surgical history and any hospitalization or doctor visits for an illness in the past year:____

· Is there any other health related information or further suggestions for camp personnel: ___________________
____

· Vegetarian? ___ Yes ___ No Any other dietary concerns? ____

____

Does your camper take Medicine? __Yes* __ No
If yes, Name of Medication____

* If yes please also complete the Request for Dispensing Medication Form

IMPORTANT—THIS BOX MUST BE COMPLETED FOR ATTENDANCE

This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted.
Emergency Authorization: I hereby give permission to the medical personnel selected by the Camp Director to order x-rays, routine tests and treatment for my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. This form may be photocopied for use out of camp. I also give permission for routine medical care as per the camp physician's standing orders for my child at YMCA Camp Ohiyesa and YMCA Camp Nissokone.

Signature of parent/guardian or adult camper/staff______________________________ Date___________________

Witness____ Date___________________

I. Camper Confidential Information

Does camper need "Toilet – Night Call?" YES ______ NO______ Is child a "Bed wetter?" YES ______ NO ______

Does camper have other night time problems, such as sleepwalking, nightmares, etc.? YES_____ NO_____
Explain: ____

Has camper ever had professional counseling? YES ______ NO______ If YES, Explain:___________________________________

Describe any Therapist recommendations that might help camper adjust to camp:___________________________________
Is your camper in his/her appropriate grade based on age? ___YES ___NO

Who encouraged your camper to attend camp? ____

Has your camper been separated from parents? YES ______ NO ______ Longest period? ________

Has camper been to an overnight camp before? YES ______ NO _____ Problems with homesickness? YES ______NO _____

Does your camper have any fears? ____

Has child been to summer camp? Camp Name: ________________________________ __DAY __RESIDENT # OF YEARS ______

II. Statement of Camper Immunizations

Please fill out the appropriate statement below regarding your campers immunization history:

I ____________________________ of ______________________ attest that all immunizations for school are up to date.
(Custodial Parent/Guardian) (Camper Name)

OR

I _______________________________ of ____________________________ choose not to immunize.
(Custodial Parent/Guardian) (Camper Name)

Signature of parent/guardian ____ Date____________________

III. Tetanus Shot/Booster Information

The date of _____________________________________(Camper Name) last Tetanus Shot/Booster is ___/___/_______.

Signature of parent/guardian ____ Date____________________

Primary Doctor & Insurance Information

Insurance Information

Name of Insurance _________________________________

ID#____

Subscribers Name __________________________________

Employer Name ____________________________________

Relationship to Child _______________________________

Name of Primary Doctor _____________________________

Doctors Office Telephone _______-________-__________

Name of Dentist ____________________________________

Dentist Office Telephone _______-________-___________

Emergency Contact Information

Emergency Contact Information

Please provide information for 2 people other than yourself that can be called in case of a medical emergency for your camper and you cannot be reached.

Emergency Contact Name: ___________________________

Contact Telephone: ________-________-________________

Relationship: ____

Emergency Contact Name: ___________________________

Contact Telephone: ________-________-________________

Relationship: ____