

HEALTH HISTORY AND EXAMINATION FORM for Children, Youth, and Adults Attending Camp

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history must be filled out by parents/guardians of minors or by adult staff members themselves. Update required annually. Health exam must be completed by an approved, licensed medical professional every year.

Dates of Camp Attendance: _____

Mail this form AT LEAST 2 WEEKS prior to attendance:

YMCA Camp Kenan
19 East Avenue
Lockport, NY 14094

PARTICIPANT INFORMATION

Name _____ Birth Date _____
Last First Middle

Social Security Number of Participant _____ Gender: Male Female Age at Camp _____

Home Address _____
Street Address City State Zip

Custodial Parent/Guardian _____ Relation: _____

Home Address _____
Street Address City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Second Parent/Guardian or Emergency Contact _____ Relation: _____

Home Address _____
Street Address City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

If Parent/Guardian not available, in an emergency notify: _____ Relation: _____

Home Address _____
Street Address City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

INSURANCE INFORMATION

It is vitally important that everyone in camp be covered by Health and Accident Insurance. The camp does not carry accident insurance on our campers. Any treatment expenses, which are not incurred as a result of the Camp's liability, MUST be covered by the camper's insurance or by the camper's parent or legal guardian. Campers are typically covered under family policies (ie. BCBS, Independent Health, etc.), Group Insurance, or Medicaid. Adult staff members may be covered under family policies or personal policies, in addition to Worker's Compensation (for job related injuries).

Is the participant covered by family Health and Accident Insurance? YES : NO

Name of Policy Holder _____ Relation: _____

Health Insurance Carrier or Plan Name _____

Agent or Company _____ Phone Number _____

Policy or Certificate Number _____ Group Number _____

➤ Photocopy of the front and back of health insurance card must be attached to this form ◀

MEDICAL PROVIDER INFORMATION

Name of Participant's Physician _____ Phone _____

Address _____
Street Address City State Zip

Name of Participant's Dentist/Orthodontist _____ Phone _____

Address _____
Street Address City State Zip

HEALTH HISTORY

Has/does the participant:

	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had joint problems? (knees, ankles, etc) ...	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems? (rash, acne, etc)	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts, or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever been diagnosed with high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" answers, noting the number of the question(s).

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp staff should be aware.

PARENT/GUARDIAN AUTHORIZATIONS

By signing this form, I agree to the following conditions:

This health history is correct and complete as far as I know. The person herein described is a healthy person who is physically, mentally, socially, and emotionally capable of the camp experience. No participant shall be brought to camp if they are known to have any contagious conditions (pink eye, lice, etc.). The participant has permission to fully engage in all camp activities, except as noted, on or off premises, subject to the policies, rules, and regulations of the YMCA and Camp Kenan.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

In the event I, or the emergency contact, cannot be reached in an emergency, I hereby give permission to the Camp Director or his/her designee, to act as the parent/guardian concerning the health and welfare of the participant. I also give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above.

As the parent/guardian of the above named child, I hereby waive, release, and forever discharge the YMCA and its officers, agents, employees, representatives, executors, and all others acting on their behalf from any responsibility or liability for any injury or damage sustained resulting from the participant's use of the YMCA's equipment or facilities or participation in YMCA activities, whether on YMCA premises or at another location. I understand the risks and dangers involved in participation in programs and activities of the YMCA. I agree to all policies set by the YMCA as written in the YMCA Membership Handbook.

The camp has permission to use any photographic or audio materials produced during the camper's participation for the purposes of record keeping or promotion.

Camp Kenan retains the right to enforce its rules, and if necessary, send home WITHOUT REFUND, any camper infringing on the rights of others or whose behavior/actions are otherwise unacceptable.

➤ _____ Signature of Parent/Guardian or Adult Staffer	_____ Printed name of Parent/Guardian or Adult Staffer	_____ Date
➤ _____ Signature of Participant	_____ Printed name of Participant	_____ Date

HEALTH HISTORY

The following information should be filled out by the parent/guardian or adult staffer **and** verified by a physician. The intent of this information is to provide camp health care personnel with the background to provide appropriate care.

MEDICATION ALLERGIES

Describe reaction and management of the reaction

FOOD ALLERGIES

Describe reaction and management of the reaction

OTHER ALLERGIES (insect stings, hay fever, asthma, animal dander, etc.)

DIETARY RESTRICTIONS

- Does not eat red meat Does not eat pork Does not eat eggs Does not eat nut products
- Does not eat poultry Does not eat seafood Does not eat dairy products
- Other (describe): _____
- Medically-prescribed meal plan (describe): _____

OTHER RESTRICTIONS

Explain any restrictions to activity. (e.g. what cannot be done, what adaptations or limitations are necessary)

HEALTHCARE RECOMMENDATION BY LICENSED MEDICAL PERSONNEL

I examined this individual on _____. In my opinion, the above applicant is is not able to participate in an active camp program.

BP _____ Weight _____ Height _____

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

Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

TB Mantoux Test
Date of last test: _____
Result: Positive Negative

Please give all dates (or attach a copy) of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
or Measles		_____	_____	_____	_____	_____	_____
or Mumps		_____	_____	_____	_____	_____	_____
or Rubella		_____	_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____	_____	_____

Signature of Licensed Medical Personnel > _____

Printed Name _____ Title _____

Address _____

Phone Number _____ Date _____ (place stamp above)

MEDICATIONS TO BE ADMINISTRED AT CAMP

Please list ALL medications (including prescribed and over-the-counter medications) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes **NO** medications on a routine basis.

This person takes medications as follows:

Med #1 _____ Dosage _____ Time(s) taken each day _____
Reason for taking _____

Med #2 _____ Dosage _____ Time(s) taken each day _____
Reason for taking _____

Med #3 _____ Dosage _____ Time(s) taken each day _____
Reason for taking _____

Med #4 _____ Dosage _____ Time(s) taken each day _____
Reason for taking _____

Additional pages attached for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer: _____

OVER-THE-COUNTER MEDICATIONS

I hereby authorize that the following medications may be given to the above name participant as the circumstances call for, unless otherwise noted.

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Ointment (antiseptic, anti-itch, anti-sting, antibiotic, sunburn) for minor wound care, first aid, etc. |
| <input type="checkbox"/> | <input type="checkbox"/> | Tylenol for fever, pain, headache, etc. as directed on bottle for age and weight |
| <input type="checkbox"/> | <input type="checkbox"/> | Ibuprofen for pain, headache, etc. as directed on bottle for age and weight |
| <input type="checkbox"/> | <input type="checkbox"/> | Throat lozenges for sore throat |
| <input type="checkbox"/> | <input type="checkbox"/> | Vitamin C supplement as needed |
| <input type="checkbox"/> | <input type="checkbox"/> | Micatin or Anti-Fungus oil as needed for athlete's foot |
| <input type="checkbox"/> | <input type="checkbox"/> | Pepto Bismol for nausea or diarrhea as directed on bottle for age and weight |
| <input type="checkbox"/> | <input type="checkbox"/> | Kaopectate for diarrhea as directed on bottle for age and weight |
| <input type="checkbox"/> | <input type="checkbox"/> | M.O.M. laxative as directed on bottle for age and weight |
| <input type="checkbox"/> | <input type="checkbox"/> | Mylanta for nausea as directed on bottle for age and weight |
| <input type="checkbox"/> | <input type="checkbox"/> | Benadryl for swelling, hives, allergic reaction, as directed on bottle |
| <input type="checkbox"/> | <input type="checkbox"/> | Medicaine Sting-Ease Swabs for insect stings |
| <input type="checkbox"/> | <input type="checkbox"/> | Actifed or Sudafed for nasal congestion or allergy relief per bottle instructions |
| <input type="checkbox"/> | <input type="checkbox"/> | Visine/Murine Plus for minor eye irritation |
| <input type="checkbox"/> | <input type="checkbox"/> | Swimmers Ear Drops as per directed on bottle |
| <input type="checkbox"/> | <input type="checkbox"/> | Hydrocortisone 0.5% for persistent rashes, poison ivy, and bug bites |
| <input type="checkbox"/> | <input type="checkbox"/> | Robitussin Cough Syrup per bottle directions |
| <input type="checkbox"/> | <input type="checkbox"/> | Calamine Lotion for bug bites and poison ivy |
| <input type="checkbox"/> | <input type="checkbox"/> | Sunscreen SPF # _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Insect Repellant |
| <input type="checkbox"/> | <input type="checkbox"/> | Epi-Pen for anaphylactic shock or questionable reactions (must be provided by parent/guardian for use with prescription) |

Restrictions/Allergies: _____

I understand that such administration will be done under the supervision of, and opinion of, the Camp Health Officer (RN, EMT, LPN) in charge.

Signature of Licensed Medical Personnel > _____

Printed Name _____ Title _____

Address _____

Phone Number _____ Date _____

(place stamp above)