- **All forms must be filled out and turned in <u>FOUR weeks before camp</u>**
- 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

Medical Information and Health History
for Children, Youth, and Adults
attending Camp Crosley YMCA

Name:_____ Birth date:_____ Age at camp:_____ Sex: M F

Last First Middle

Mother/Guardian 1:_____ Home Phone: (____)_____

Work Phone: (____)_____ Cell Phone: (____)_____

Home address:_____ _____ _____ _____

Street address City State Zip

Father/Guardian 2: _____ Home Phone: (____)_____

Work Phone: (____)_____ Cell Phone: (____)_____

Home Address: _____ _____ _____ _____

Street address City State Zip

<u>Emergency Contact Information, please notify:</u>

Name: _____ Home Phone: (___)_____

Work Phone: (___)_____ Cell Phone: (___)_____

Name: _____ Home Phone: (___)_____

Work Phone: (___)_____ Cell Phone: (___)_____

<u>General Information:</u>

Height:_____

Weight:_____

Blood Pressure: _____

Last Exam Date: _____

<u>Allergies and Dietary Restrictions:</u>

<u>Does your child require an EpiPen?</u> _____

<u>Please provide details about your child's anaphylaxis, including the date and description of the reaction:</u>

_____ _____

Does your child have any dietary restrictions? _____

Please explain **<u>:</u>**_____

<u>Allergies:</u> <u>(list all known)</u>

Medication, food, or other allergies (list): Describe reaction and management to reaction:

_____ _____

_____ _____

_____ _____

Health History-to be completed by Parent/Guardian

Medications and Treatments:

□ **This person takes NO medications on a routine basis.** □ **I do give permission for camp to give medications.**

Please list all medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at Camp Crosley YMCA. 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.

Is there anything the camp needs to be aware of when giving any of the approved over-the- counter medications to your child? _____

Will you child require any treatments while at camp? _____

Please explain what treatment (s) must be given to your child, including the frequency. _____

Does your child regularly take any medications that will not be taken at camp? _____

Explain what medications your child takes regularly and why they are taken. _____

This person takes the medications as follows:

Med #1 _____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Med#2 _____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Med# 3_____ Dosage _____Specific times taken each day_____

Reason for taking_____

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

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

_____

Immunizations:

Please give all dates of immunization for (**we accept copies of immunization cards**):

Vaccination	**Yes/No**	Dates: **Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**	**Mo/Yr**
TB	____	____	____	____	____	____
Chicken Pox (Vaircella)	____	____	____	____	____	____
DTP (diphtheria/Pertussis, Tetanus, Polio)	____	____	____	____	____	____
Haemophilus Influenza B	____	____	____	____	____	____
Hep A	____	____	____	____	____	____
Hep B	____	____	____	____	____	____
HPV	____	____	____	____	____	____
IPV/OPV	____	____	____	____	____	____
MMR	____	____	____	____	____	____
PCV (Pneumococcal)	____	____	____	____	____	____
Meningococcal Meningitis (MCV4)	____	____	____	____	____	____

TB Mantoux Test

Date of last test_____

Result: Positive/Negative

If your child has not been fully immunized, please explain. _____

Has your child had a TB Mantoux test? _____

What was the result of your child's most recent TB Mantoux Test? _____

Date of most recent TB Mantoux test. _____

Please explain your child's positive result on the TB Mantoux test. _____

Medical Conditions

Has/does the participant:	YES/NO	Details:
ADD/ADHD		
AIDS/ARD		
Asthma/Inhaler		
Athlete's Foot		
Back Pain or Injury		
Bedwetting		
Behavioral Issues		
Blackouts/Fainting		
Bleeding Disorder		
Cancer		
Chest pain		
Crohn's		
Colitis		
Concussion		
Constipation/Diarrhea		
Convulsions		
Dental Braces, Caps, or Bridges		
Depression		
Developmental Delays		
Diabetes		
Down's Syndrome		
Ear Infections		
Eating Disorder		
Epilepsy		
Excessive weight gain/loss		
Fetal Alcohol Syndrome		
Frequent colds		
Hay Fever		
Headaches		
Hearing Problems		
Heart Disease		
Hernia		
High Blood Pressure		
Homesickness		
Irritable Bowel Syndrome		
Kidney Disease		
Lice		
Menstrual Difficulties		
Mental Health Issues		
Motion Sickness		
Mouth Injuries		
Neck Pain or Injury		
Nightmares/Terrors		
Pneumonia		
Problems Breathing or Coughing		
Respiratory Ailments		
Rheumatic Fever		
Seizures		
Sinus Infections		
Skin Problems		
Sleepwalking		
Sore Throats		
Speech Problems		
Stomach Aches		
Tonsillitis		
Ulcer		
Urinary Tract Infection		
Uses eye glasses or contacts		
Visual Problems		
Other		
Disease:	**YES/NO**	**Details:**
Chicken Pox (Varciella)		
Hep A, Hep B, Hep C		
Measels (German)		
Measels (Red)		
Mono (past 1 year)		
Mumps		
Rheumatic Fever		
Scarlet Fever		
Whooping Cough		

	YES/NO	Details:
Has your child had any operations?		
Please explain the operation (s), including date (s)		
Have they been hospitalized or had a serious injury?		
Please explain the reason for hospitalization (s) or the serious injury and the dates.		
Has your child been exposed to any communicable diseases within the last 3 months?		
Please explain what disease and date of exposure.		
Does your child have any restrictions on activity?		
Please explain what activities and list any special accommodations needed.		
Will your child require any special assistance while at camp?		
Please explain what assistance will be needed.		
Is there anything you would like to discuss with the camp medical staff?		
Please explain what you would like to discuss with the camp medical staff?		
Please explain any other medical information the camp should have about your child.		
Doctor Information:	**Name:**	**Phone Number:**
Health Information:		
Do you have medical insurance?		
Full Name of Policy Holder		
Policy Holder Phone Number		
Employer Name (if insured through company)		
Insurance Company/Plan Name		
Insurance Company Phone Number		
Health Insurance Policy Number		
Insurance Group Name or Number		

Medical Waiver

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to Camp Crosley YMCA to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR I 165.510 (b) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in the camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

I give my permission for Camp Crosley YMCA to administer over-the-counter, non-prescription medications, or ointments as prescribed for age and weight.

Signature of **parent**/guardian or adult camper/staff_____

Printed Name_____

Date_____