

Camper Name: _____ Session#/Name: _____ Year: _____

Health History, Medication, and Examination Form (PAGE 1)

*****Please complete this page fully for each camper*****

Camper Birth Date: _____ / _____ / _____ Age at Camp: _____ Gender: ___ Male ___ Female

Custodial Parent/Guardian: _____ Home Phone: _____

Home Address: _____
Street Address City State Zip

Work Phone: _____ Cell Phone: _____

Second Parent / Guardian / Emergency Contact Name: _____

Home Address: _____ Phone: _____
Street Address City/State/Zip

Work Phone: _____ Cell Phone: _____

If not available in an emergency, notify: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance Information

Is the camper covered by Medical Insurance? ___ Yes ___ No

Name of Policy Holder: _____ Policy Holder Birthday: _____ / _____ / _____

Carrier Name: _____ Group #: _____ Policy# _____

Carrier Address/Phone: _____
Street Address City/State/Zip/Phone

Policy Holder Social Security Number or ID Number: _____

Important - The information below must be completed for attendance*

I hereby give permission to the medical personnel selected by the Camp Director to provide routine health care; to administer medications; to order X-rays; routine tests; treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physicians selected by the Camp Director to secure and administer treatment, including hospitalization for the person named above. YMCA Camp Pinewood will make every attempt to notify you before making a doctor's appointment or an emergency room visit for your child while they are in our care. All minor medical needs will be cared for by the on-site Health Director without notification of parents.

Parent/Guardian Signature: _____ Date: _____

**If for religious reason you cannot sign this, contact the camp for a waiver, which must be signed.*

Will the camper have any medication, prescription or non-prescription, over-the-counter drugs, inhalers, epi-pens, vitamins, minerals, herbs, and/or medical procedures needed or provided at camp. ___ YES ___ NO

Does your camper have any Allergies. ___ YES ___ NO

If YES to either, please fill out PAGE 2 of this form.

Camper Name: _____ Session#/Name: _____ Year: _____

Health History and Examination Form (PAGE 2)

*****Please complete for each camper with any Medication and or Allergies*****

Medication Procedures

- Please list all medication prescription or non-prescription, over-the-counter drugs, inhalers, epi-pens, vitamins, minerals, herbs and or medical procedures taken regularly or as-needed basis by the camper.
- **Leave in the original container**, pack enough to last the entire stay at camp. Make sure that all of the above listed and prescription drugs are in the original container that includes the physician name, medication name and dosage/administration instructions.
- **Put all medications into a sealed clear plastic bag labeled with the camper's name and take it to the check-in or the bus stop.** Please **DO NOT** pack medications in your camper's luggage.

This camper takes the following medications or needs the following medical procedures:

- **Medication:** _____ Reason for taking: _____

Frequency: (Check One) ___ Daily ___ As-Needed ___ Other/Please Explain _____

Times: ___ Breakfast ___ Lunch ___ Dinner ___ Bed Time ___ Other Time Please Explain _____

Other Dosage/Administration Instructions Comments: _____

-**Medication:** _____ Reason for taking: _____

Frequency: (Check One) ___ Daily ___ As-Needed ___ Other/Please Explain _____

Times: ___ Breakfast ___ Lunch ___ Dinner ___ Bed Time ___ Other Time Please Explain _____

Other Dosage/Administration Instructions Comments: _____

-**Medication:** _____ Reason for taking: _____

Frequency: (Check One) ___ Daily ___ As-Needed ___ Other/Please Explain _____

Times: ___ Breakfast ___ Lunch ___ Dinner ___ Bed Time ___ Other Time Please Explain _____

Other Dosage/Administration Instructions Comments: _____

-**Medication:** _____ Reason for taking: _____

Frequency: (Check One) ___ Daily ___ As-Needed ___ Other/Please Explain _____

Times: ___ Breakfast ___ Lunch ___ Dinner ___ Bed Time ___ Other Time Please Explain _____

Other Dosage/Administration Instructions Comments: _____

Allergies / Medical Procedures: (please list any food, environmental, medication allergies or medical procedures)

If space is needed for any other medication or procedures please print a second copy of this page and attach.

Camper Name: _____ Session#/Name: _____ Year: _____

Health History and Examination Form (PAGE 3)

*****Please complete for each camper if doctor signed physical is not attached*****

Health Care Examination/Recommendations by Licensed Medical Personnel

The Health Care Examination section must be completed by a licensed physician before attending camp. If the camper has had a doctor's examination within 24 months of their camp session then that examination form may be attached in place of this page. Please include an immunization history as well.

(Below is for Doctors Office Use Only)

Camper Name: _____ I examined the individual on ____/____/____ (date)

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

_____ Weight _____ Blood Pressure _____ Eyes _____ Glasses _____ Ears _____ Nose
_____ Throat _____ Posture/Spine _____ Skin _____ Teeth _____ Heart _____ Lungs
_____ Abdomen _____ Extremities _____ Hernia _____ Other: _____

Explanation of any checked: _____

Females: Menstrual History Normal _____ Special Considerations _____

Recommendations and Restrictions at Camp

Treatment to be continued at camp: _____

Medically-prescribed meal plan/dietary restrictions: _____

Medication Allergies: Describe reaction and management/treatment

Food Allergies / Dietary Restrictions: Describe reaction and management/treatment

Other Allergies Describe reaction and management/treatment

Restrictions / Limitation of camp activities (e.g. what cannot be done, what adaptations are necessary, etc.)

Has the camper had or have any recent illness, mental illness, injury or infectious disease? ___ Yes ___ No

If yes, please explain: _____

Health History (if any checked please put the date of the last record incident)

___ Chicken Pox ___ Ear Infections ___ Migraines ___ Mononucleosis ___ Measles ___ Rheumatic Fever
___ Nosebleeds ___ Convulsions ___ Surgeries ___ German Measles ___ Dizziness ___ Behavior Issues
___ Seizures ___ Diabetes ___ Mumps ___ Eating Disorders ___ Asthma ___ Heart Murmur

Other health or dental concerns or details of any of the above: _____

Immunization History (Please list dates as accurately as possible)

_____ DPT Series _____ Booster _____ Tetanus Booster _____ Hepatitis B Series
_____ Polio OPV (Sabin) _____ Booster _____ Tuberculin Test _____ MMR
_____ Other (please list) _____

I have examined the person described and have reviewed his/her health history. It is my opinion that the above named camper is physically able to engage in camp activities, except as noted.

Physician Signature: _____ **Date:** ____/____/____