

Camp Health History Form For Children, Youth and Adults

Return to Group Leader

The following information must be filled in by the parent/guardian/adult. Please provide complete information so that the camp can be aware of your needs.

Camper's Name: _____ Sex: ____ Birth Date: _____ Age: ____

Parent or Guardian: _____

Home Address: _____
Street and Number City State Zip Code

Phone number (home): _____ (work) _____ email: _____

Family Doctor: _____ Phone: _____

----- In an emergency, if unable to reach parent/guardian, contact -----

Name: _____ Phone: _____

Name: _____ Phone: _____

----- Does the participant have any problems with the following? -----

yes	no		yes	no	yes	no	
___	___	Asthma	___	___	Envirnon. Allergies	___	___
___	___	Seizures	___	___	Hearing loss	___	___
___	___	Diabetes	___	___	Heart Problems	___	___
___	___	High Blood Pressure				___	___
						___	___
						___	___
						___	___

If yes, please explain: _____

Does this participant have any other serious medical problems, or been physicians care recently? ___ yes ___ no

If yes, please explain: _____

If you have any doubts that the participant is in good health, have him/her checked by your family doctor and forward the report to the group leader. Please do not send your participant to Camp Wood if he/she has cold or flu symptoms.

Does the participant have any allergies to food? _____

Allergies to medications? _____

Diet restrictions? _____

Has the participant received all required immunizations? ___yes ___ no Date of last tetanus shot? _____

-----Medications-----

The participant may not have any medications (pill or oral liquid) in his/her possession. This includes over the counter medications like Tylenol. All medications must be given to and be held by the group leader or Health Officer, who will administer medications according to written instructions. All medications must be in original pharmacy containers with participant's name on the bottle.

The group leader has my permission to give me/my child over the counter medication if needed (please check) ___ yes ___ no

Please list any exceptions _____

List the medications the participant must take on a regular schedule

Medication	What it is for	Dosage	How Often	When
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Is the participant afraid of water? ___ yes ___ no What is the participant's swimming ability? _____

To the best of my knowledge the above information given is correct and the participant named above has permission to engage in all camp activities. In case of medical emergency, I understand I will be notified as soon as possible by the group leader. I hereby give permission to the physician selected by the group leader to hospitalize, secure treatment for and to order injections, anesthesia or surgery for the participant named above. I also give permission for a group adult representative to transport the participant to the hospital or medical/dental office in their own vehicle if needed. Any directions to the contrary should be specified at the bottom of this form and signed. I understand and am aware that I/my child will be participating in many physical activities and the potential for accidents does exist. In consideration of acceptance to Camp Wood YMCA, on behalf of my child, myself, my heirs, personal representatives and next of kin, I hereby release and discharge Camp Wood YMCA I, indemnify and hold harmless Camp Wood and/or its staff from any and all liability, claims, damage, injury or illness sustained to my child. I understand accident insurance is not provided by Camp Wood YMCA. Should camper require medical treatment, prescriptions, or hospital care during the camp session, parents shall bear all expenses. I agree that Camp Wood may photograph or video tape the participant for use in promotional materials. Finally, I give permission to share any pertinent medical information to the Camp Wood YMCA staff.

Parent/Guardian/Adult Name: _____ Signature: _____ Date: _____