

CAMP SPEERS-ELJABAR YMCA
PLEASE RETURN BY JUNE 1, 2010

HEALTH HISTORY & EXAMINATION FORM ~ (For children, youth and adults attending Camp Speers-Eljabar YMCA)

The information on this form is not part of the camper or staff acceptance process, but gathered to assist us in identifying appropriate care. Health history (first two pages) must be filled out by parents/guardians of minors or by adults themselves. Update required annually. Health Exam (Page 3) must be completed by approved licensed medical personnel annually.

Sessions of Camp Attendance: _____

Name _____ Birth Date _____ Age at Camp _____
 Last First Middle Init.

Home Address _____

Soc. Sec. No. Participant _____ Gender: Male Female

Custodial parent/guardian _____ Home # _____

Cell Phone _____ Work # _____

Home Address _____

(If different from above) Street Address City State Zip Code

Business Address _____

Street Address City State Zip Code

Second Parent, guardian or emergency contact _____

Address _____ Home # _____

Street Address City State Zip Code

Cell Phone _____ Work # _____

Business Address _____

Street Address City State Zip Code

If not available in an emergency, notify:

Name _____

Relationship _____ Home # _____

Cell Phone _____ Work # _____

Address _____

Street Address City State Zip Code

Parent/Guardian Authorizations: This health history is correct and complete to the best of my knowledge. The person herein described has permission to engage in all camp activities except as noted.

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

Signature of parent/guardian or adult camper/staffer _____

Printed Name _____

Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities

Signature of parent/guardian or adult camper/staffer _____

Date _____

NOTARY SECTION

Year

Cabin or Group

Name

Health History ~ (To be completed by parent)

Allergies

List all known allergies. Describe reaction and management of reaction.

No known allergies

Restrictions

The following restrictions apply to this individual

Dietary

- | | | |
|--|---|--|
| <input type="checkbox"/> Does not eat red meat | <input type="checkbox"/> Does not eat pork | <input type="checkbox"/> Does not eat eggs |
| <input type="checkbox"/> Does not eat poultry | <input type="checkbox"/> Does not eat seafood | <input type="checkbox"/> Does not eat dairy products |
| <input type="checkbox"/> Other _____ | | |

Activities

Please explain any (e.g. what cannot be done, what adaptations or limitations are necessary)

General Questions (Explain "yes" answers below)

Has/Does the participant:	YES	NO		YES	NO
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	16. Have an orthodontic appliance brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	17. Have any skin problems (e.g. itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	20. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts, or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	21. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	22. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	23. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	24. Ever had problems with joints (e.g. knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	25. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. 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.

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

Name of family physician		Phone	
Address			
Name of family dentist/orthodontist		Phone	
Address			

Physician's Section ~ Physical Exams required within 24 months of camp. Physician must complete & sign this section annually.

I examined _____ on _____
 Blood Pressure _____ Weight _____ Height _____
 In my opinion, the above applicant is is not, able to participate in an active camp program

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

Medications to be administered at camp: Place initials in yes/no box for authorization of standard over-the-counter medications to be administered at the discretion of the RN. Please write out any other **over-the-counter or prescription medications in the remaining space**. Must include medication name, route, dose, frequency, and duration to be administered at camp.

- Yes** **No** Tylenol PO per label instructions by age/weight Q4H PRN for pain or fever > 100.5
- Yes** **No** Ibuprofen PO per label instructions by age/weight Q6H PRN for pain or fever > 101.5
- Yes** **No** Sudafed PO per label instructions by age/weight Q4H PRN for nasal congestion not to exceed 4 doses in 24 hours
- Yes** **No** Ludens Throat Lozenges PO per label instructions by age/weight for cough
- Yes** **No** Robitussin PO per label instructions by age/weight Q4H PRN for cough
- Yes** **No** Calamine Lotion TOPICAL per label instructions for allergic reactions/pruritus
- Yes** **No** Benadryl PO per label instructions Q6H PRN for allergic reactions

Other medications: _____

Treatments to be continued at camp: _____

Known Allergies _____

Description of any limitations or restrictions on camp activities: _____

Check box if the participant has had:
 Measles Chicken Pox German Measles Mumps Hepatitis A B C

Please give dates of immunization:

VACCINE: DATES:		MO/YR	MO/YR	MO/YR	MO/YR	MO/YR	MO/YR
DPT							
TD (Tetanus/Diphtheria)							
Tetanus							
Polio							
MMR							
	Measles or						
	Mumps or						
	Rubella						
Haemophilus Influenza B							
Hepatitis B							
Varicella (Chicken Pox)							
Meningitis							
TB Mantoux Test Results		<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date last test			
Signature of Licensed Personnel:							
Printed:						Title:	
Address							
Phone:					Date:		

Insurance Information ~ (To be completed by parent)

Insurance Information:

Is the participant covered by family medical/hospital insurance Yes No

If so, indicate carrier or plan name: _____ Group # _____

Subscriber Name: _____ Subscriber's Date of Birth: _____

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

For Camp use only (Screening Record)

Updates/additions to health history noted Yes No None Required

Current health needs identified:

Observational Notes:

Screened by:

Screening Notes:				
Date/Time				
Screened:		Head		Throat
		Feet		Temperature
	By:		Date:	

Medications Received:

	By:		Date:	

Updates to Health Information:

	By:		Date:	