



Health History and Examination Form
For Children, Youth, and Adults
Attending Camp Crosley YMCA

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 (first two pages) must be filled out by parents/guardians of minors or by adults themselves annually. Health exam (third page) must be completed by approved licensed medical personnel at least every two years.

Name: _____ Birth date: _____ Age at camp: _____ Sex: M F
Last First Middle

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

Home address: _____
Street address City State Zip

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

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

Home Address: _____
Street address City State Zip

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

If neither of the above are available in an emergency, please notify:

Name: _____ Home Phone: (____) _____

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

Name: _____ Home Phone: (____) _____

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

Name of family physician: _____ Phone(____) _____

Name of family dentist/orthodontist _____ Phone(____) _____

Is the participant covered by family medical/hospital insurance? ____ If so, indicate carrier or plan name _____

Policy or Group # _____ Membership Services Phone # _____

Important-These boxes must be complete for attendance*

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

Signature of parent/guardian or adult camper/staff _____

Printed Name _____ Date _____

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 § 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 _____ Date _____

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

Signature of minor or adult camper/staffer _____ Date _____

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

IMPORTANT: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance, or if camper has been seen by a physician for any reason during this period.

Health History-To be completed by Parent/Guardian

Allergies (list all known) Describe reaction and management to reaction

Medication, food, or other allergies (list)

Medications Being Taken

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.

_____ This person takes NO medications on a routine basis.

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 _____

Attach additional pages for more medications.

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

Restrictions

List any dietary restrictions: _____

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

General Health Questions

Has/does the participant:

- | | |
|---|--|
| <input type="checkbox"/> 1. Had any recent injury, illness or infectious disease? | <input type="checkbox"/> 16. Ever been diagnosed with heart disease, illness, murmur? |
| <input type="checkbox"/> 2. Have a chronic or recurring illness/condition? | <input type="checkbox"/> 17. Have any skin problems (e.g. itching, rash, ache)? |
| <input type="checkbox"/> 3. Ever been hospitalized? | <input type="checkbox"/> 18. Have diabetes? |
| <input type="checkbox"/> 4. Wear glasses, contacts, or protective eye wear? | <input type="checkbox"/> 19. Ever had emotional difficulties for which professional help was sought? |
| <input type="checkbox"/> 5. Ever had frequent ear infections? | <input type="checkbox"/> 20. Ever had problems with joints (e.g. knees, ankles)? |
| <input type="checkbox"/> 6. Ever had a head injury? | <input type="checkbox"/> 21. Have an orthodontic appliance being brought to camp? |
| <input type="checkbox"/> 7. Ever had surgery? | <input type="checkbox"/> 22. Have asthma? |
| <input type="checkbox"/> 8. Have frequent headaches? | <input type="checkbox"/> 23. Ever had an eating disorder? |
| <input type="checkbox"/> 9. Ever been knocked unconscious? | <input type="checkbox"/> 24. Have a history of bed-wetting? |
| <input type="checkbox"/> 10. Ever passed out during or after exercise? | <input type="checkbox"/> 25. Had mononucleosis in the past 12 months? |
| <input type="checkbox"/> 11. Ever been dizzy during or after exercise? | <input type="checkbox"/> 26. Have problems with sleepwalking? |
| <input type="checkbox"/> 12. Ever had seizures? | <input type="checkbox"/> 27. Had problems with diarrhea/constipation? |
| <input type="checkbox"/> 13. Ever had chest pain during or after exercise? | <input type="checkbox"/> 28. If female, have an abnormal menstrual history? |
| <input type="checkbox"/> 14. Ever had high blood pressure? | |
| <input type="checkbox"/> 15. Ever had back problems? | |

Please explain any checked answers, noting the number of the questions.

Which of the following Please give all dates of immunization for:

Has the participant had?	Vaccine	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Measles	DTP		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Chicken pox	TD(tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> German measles	Tetanus		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Polio		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	MMR		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	or Measles		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Mumps		_____	_____	_____	_____	_____	_____
	or Rubella		_____	_____	_____	_____	_____	_____
TB Mantoux Test	Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B		_____	_____	_____	_____	_____	_____
Result: Positive/Negative	Varicella (chicken pox)		_____	_____	_____	_____	_____	_____

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

Medical Examination-To be filled out by a licensed physician

This examination should be performed within 24 months of arrival at camp. Examination for some other purpose within this period is acceptable (i.e. school physical, sports physical).

I examined this individual on _____.

BP _____ 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

Recommendations and Restrictions at Camp

Treatment to be continued at camp

Medications to be administered at camp (name, dosage, frequency)

Known allergies

Description of any limitation or restriction on camp activities

Additional information for health care staff at the camp

Signature of Licensed Medical Personnel _____

Printed _____ Title _____

Address _____

Phone _____ Date _____

Nurse Check-In (For Office Use Only)

Allergies to medications: _____

Recent illness or injuries: _____

Any medications changed since this form was filled out: _____

Any other healthcare considerations shared: _____

Any extra notes:

Nurse's Signature: _____

Date: _____