Health History and Examination Form
for Children, Youth, and Adults
attending Camp Crosley YMCA

- **All forms must be filled out each year & turned in FOUR weeks before camp**
- We can not accept fax, email, or copies of any kind – **we must receive originals**
- Physicals must be filled out by a physician and are valid for 24 months (only Physicals and Immunization Records **can** be copies)
- 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

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

If neither of the above is 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 herby 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.

*Signature of **parent**/guardian or adult camper/staff*_____
Printed Name_____ Date_____

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 **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)

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

_____ _____

_____ _____

_____ _____

Medications Being Taken:

□ **This person takes NO medications on a routine basis.**

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 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_____

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:

___1. Had any recent injury, illness or infectious disease?
___2. Have a chronic or recurring illness/condition?
___3. Ever been hospitalized?
___4. Wear glasses, contacts, or protective eye wear?
___5. Ever had frequent ear infections?
___6. Ever had a head injury?
___7. Ever had surgery?
___8. Have frequent headaches?
___9. Ever been knocked unconscious?
___10. Ever passed out during or after exercise?
___11. Ever been dizzy during or after exercise?
___12. Ever had seizures?
___13. Ever had chest pain during or after exercise
___14. Ever had high blood pressure?
___15. Ever had back problems?
___16. Ever been diagnosed with heart disease, illness, murmur?
___17. Have any skin problems (e.g. itching, rash, ache)?
___18. Have diabetes?
___19. Ever had emotional difficulties for which professional help was sought?
___20. Ever had problems with joints (e.g. knees, ankles)?
___21. Have an orthodontic appliance being brought to camp?
___22. Have asthma?
___23. Ever had an eating disorder?
___24. Have a history of bed-wetting?
___25. Had mononucleosis in the past 12 months?
___26. Have problems with sleepwalking?
___27. Had problems with diarrhea/constipation?
___28. If female, have an abnormal menstrual history?

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

_____

Which of the following illnesses has the participant had?

___Measles
___Chicken pox
___German measles
___Mumps
___Hepatitis A
___Hepatitis B
___Hepatitis C

TB Mantoux Test

Date of last test_____
Result: Positive/Negative

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

Vaccine	Dates: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	____	____	____	____	____	____
TD(tetanus/diphtheria)	____	____	____	____	____	____
Tetanus	____	____	____	____	____	____
Polio	____	____	____	____	____	____
MMR	____	____	____	____	____	____
or Measles	____	____				
or Mumps	____	____				
or Rubella	____	____				
Haemophilus influenza B	____	____	____	____		
Hepatitis B	____	____	____			
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). **We accept copies of physical forms.**

Name_____ DOB_____

I examined this individual on _____.

Month/Day/Year

BP_____ Weight_____ Height_____

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:

_____

_____

In my opinion, the above applicant □ is or □ is not able to participate in an active camp program.

Signature of Licensed Medical Personnel _____

*Printed Name*_____ *Title*_____

*Address*_____

*Phone*_____ *Date*_____

Nurse Check-In (**For Camp Office Use Only**)

Allergies to medications:

_____

_____

_____

_____

Any recent injuries:

_____

_____

_____

_____

Any medications changed since this form was filled out:

_____

_____

_____

_____

Any sores or open wounds:

_____

Has had or has been exposed to anyone that was ill or had a fever:

_____

Has had or has been exposed to anyone with head lice:

_____

Has had or has been exposed to anyone with a contagious or infectious disease:

_____

_____

Any extra notes:

Nurse's Signature:_____ Date:_____