YMCA CAMP U-NAH-LI-YA HEALTH FORM 2012

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Suring, WI 54174
Phone 715.276.7116
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Health forms must be completed and signed by parents/guardians and must be updated annually. Participants must have had an examination within 24 months of participation, and the health form must be signed by their licensed medical professional.

SESSION ATTENDING

1	2	3	4	5	6	7	8
June 17-22	June 24-29	July 8-13	July 15-20	July 22-27	July 29-August 3	August 5-10	August 12-17

CAMPER INFORMATION

Name ______________________ Date of Birth ____________ Age at Camp ________

Home address ______________________ Home Phone ______________________

______________________ Work Phone ______________________

Custodial Parent/Guardian ______________________ Cell Phone ______________________

EMERGENCY CONTACT INFORMATION

Name ______________________ Home Phone ______________________

Relationship ______________________ Work Phone ______________________

Cell Phone ______________________

INSURANCE INFORMATION

Is the participant covered by medical insurance? ☐ Yes ☐ No

Insurance Company ______________________ Phone ______________________

Primary Carrier ______________________ Group # ______________________

HEALTH HISTORY

The intent of this information is to provide camp health care personnel the background to provide appropriate care. Any changes to this information should be provided to camp personnel upon the participant's arrival to camp.

ALLERGIES | List all known

Medication Allergies ______________________

Food Allergies ______________________

Other Allergies (hay fever, dander, insects, etc.) ______________________

DIETARY RESTRICTIONS | Check all that apply

Does not eat ☐ Red Meat ☐ Pork ☐ Eggs ☐ Dairy ☐ Seafood ☐ Poultry ☐ Other ____________

Physical Restrictions | Explain any restrictions to activity (e.g. what cannot be done, what adaptations are necessary)

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GENERAL HEALTH QUESTIONS (please explain "yes" answers below)

Has/does the camp participant:	Yes	No
1. Had recent injury, illness or disease?	☐	☐
2. Have a chronic illness or condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Have frequent sinus infections?	☐	☐
5. Have frequent headaches?	☐	☐
6. Have frequent stomach upsets?	☐	☐
7. Wear glasses or contacts?	☐	☐
8. Have frequent ear infections?	☐	☐
9. Ever been dizzy during exercise?	☐	☐
10. Ever had a seizure?	☐	☐
11. Ever had heart problems?	☐	☐
12. Have an orthodontic appliance?	☐	☐
13. Have any skin problems?	☐	☐
14. Have diabetes?	☐	☐
15. Have asthma?	☐	☐
16. Had problems with diarrhea?	☐	☐
17. Had problems with constipation?	☐	☐
18. Have problems with sleepwalking?	☐	☐
19. If female, have abnormal menstruation?	☐	☐
20. Have a history of bed-wetting?	☐	☐
21. Ever had an eating disorder?	☐	☐

Explain "yes" response, noting the question number, please | ______________________

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SWIMMING ABILITY (Circle One): Non-swimmer Beginner Intermediate Advanced

IMMUNIZATION HISTORY (feel free to attach record from physician's office)

	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP/DTaP/DT/Td	______	______	______	______
Polio	______	______	______	______
Hepatitis B	______	______	______	
MMR	______	______		
Varicella (chicken pox)	______	______		
Tdap (if applicable)	______			

Please use this space to provide any additional information about the participant's physical, emotional, or mental health which you feel camp should be aware of ______________________________

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MEDICATIONS Please list ALL medication (including over-the-counter, herbal, and non-prescription drugs) taken routinely by the camp participant. Bring enough medication to last for the camp session to the Camp Nurse upon check-in. **MEDICATION MUST BE IN THE ORIGINAL PACKAGING OR BOTTLE THAT IDENTIFIES THE PRESCRIBING PHYSICIAN, THE NAME OF MEDICATION, DOSAGE, AND FREQUENCY OF ADMINISTRATION**. Check appropriate box.

☐ This person takes no medication on a routine basis and will not be bringing any medication to Camp U-Nah-Li-Ya.

☐ This person will be bringing medication to YMCA Camp U-Nah-Li-Ya as follows;

Medication 1 ______________________________ Reason ______________________________
Dosage amount/frequency ______________________________
Dispensing Time Check Box(es) ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other ________

Medication 2 ______________________________ Reason ______________________________
Dosage amount/frequency ______________________________
Dispensing Time Check Box(es) ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other ________

Medication 3 ______________________________ Reason ______________________________
Dosage amount/frequency ______________________________
Dispensing Time Check Box(es) ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other ________

PHYSICIAN INFORMATION – Must be reviewed and signed prior to camp attendance

Name of Physician | ______________________________ Phone ______________

Health Care Facility & Address | ______________________________

Date of most recent examination | ______________

The above child has been examined, health history and immunization records have been reviewed.

There are no apparent medical conditions to prevent this child from participation in normal camp activities.

Signature of Licensed Medical Personnel | ______________________________ Date | ______________

PARENT-GUARDIAN AUTHORIZATION | Important - Must be signed for camp attendance

This health history is correct and complete to the best of my knowledge. I give permission for the child herein described to participate in all camp activities except those noted above. I hereby give permission to the camp and personnel to provide routine health care and administer prescribed medications. In case of a life or death emergency, I hereby give permission to the physician or facility selected by YMCA Camp U-Nah-Li-Ya to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my above named child in the event that I cannot be reached. The Camp and employed personnel shall be relieved of any responsibility.

Signature of Parent/Guardian | ______________________________ Date | ______________