

YMCA Camp Bishop Health & Medical History Form

- ▲ The information on this form helps us provide the best care for your child; please notify camp staff if there are changes to this form.
- ▲ All medications (prescription, over-the-counter, & supplements) brought to camp must be listed on this form and in their original container.
- ▲ This form is used strictly as confidential health information. Information important for your child's cabin leader to know should be repeated on the "Letter to my Child's Leader."

Camper Name _____
Last First Middle Initial

Home Address _____

City _____ State _____ Zip _____

Home Phone () _____ Gender M F Birthdate _____

Grade as of 9/09: _____ Age: _____

Camper lives with (circle one): Mother / Father / Both: together / Both: separately / Other: _____

1st Parent's/Guardian's Name _____

Home Phone _____ Work Phone _____ Cell Phone _____

2nd Parent's/Guardian's Name _____

Home Phone _____ Work Phone _____ Cell Phone _____

Home Address (if different from above) _____

City _____ State _____ Zip _____

Additional Contacts – If the above are unreachable these will be contacted in case of camper illness/behavior

1. Name _____ Relationship to Camper: _____
Home Phone _____ Work Phone _____ Cell Phone _____

2. Name _____ Relationship to Camper: _____
Home Phone _____ Work Phone _____ Cell Phone _____

Insurance Information – Is the participant covered by family medical/hospital Insurance? Yes No

Carrier/plan name _____ Group # _____ ID# _____

Name of Insured _____ Relationship to Camper _____

First Aid / Medical Treatment at Camp

The following over-the-counter medications are used at camp. Feel free to cross out any products that you do NOT want your child to have.

I give permission for the following medications to be administered for common ailments:

Sunscreen	Pepto Bismol	Saline Eye Drops	Tums	Bee Sting Swabs	1% hydrocortisone Cream
Tylenol	Advil	Cough Drops		Aloe Vera gel	Triple Antibiotic Cream

Authorization to Provide Necessary Treatment or Emergency Care

I hereby give permission to medical personnel selected by the camp director to order x-rays, routine tests, or other treatment; to release any records necessary for insurance purposes; to release a diagnosis and prescription to camp staff; and to provide or arrange any necessary related transportation for my child. If I cannot be contacted, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization. Both sides of this form are correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted on this form.

Parent/Guardian's Signature _____ Date _____

Please print name _____ *Please complete both sides of this form.*

Health History

Has/does the participant:

	YES	NO		YES	NO
1. Had any recent injury, illness or infectious disease?.....	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g. knees, ankles)?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a cronic or recurring illness/condition?.....	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems? (e.g. itching, rash, acne)?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?.....	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>	23. Have problems with sleepwalking?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts, eyewear?.....	<input type="checkbox"/>	<input type="checkbox"/>	24. Had problems with diarrhea/constipation?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?.....	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?.....	<input type="checkbox"/>	<input type="checkbox"/>	28. Have an eating disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	29. Have ADD or ADHD?.....	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>	30. Had a physical exam in the past year?....	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever been diagnosed with a heart murmur?.....	<input type="checkbox"/>	<input type="checkbox"/>	31. Traveled abroad in the past month?.....	<input type="checkbox"/>	<input type="checkbox"/>
16. Ever had back problems?.....	<input type="checkbox"/>	<input type="checkbox"/>			

Explain any "yes" answer, noting the number of the questions.

Allergies (Medication, Food, Other)

Reaction and management of the reaction

Please provide additional information about the participant, such as their general behavior; physical, emotional, or mental health; significant life event that might affect behavior; and dietary or other restrictions.

Immunizations Give month & year of the last immunization/booster, or attach a copy of official record:

_____ Tetanus _____ Measles/Mumps/Rubella _____ Hepatitis A _____ Meningitis
 _____ Chicken Pox _____ Diphtheria/Pertussis(DtaP/DT) _____ Hepatitis B _____ Other/Specify:

Medications

Identify medications taken during the school year that participant is NOT taking at YMCA Camp Bishop:

List all medications brought to camp. Attach additional paper as necessary. Keep medications in original packaging; prescription original packaging must identify the prescribing physician, medication name, dosage, and frequency of administration.

This person takes medications as follows:

This person takes **NO** routine medications.

Med. #1 _____ Reason for taking _____ Side effects: _____
 Time _____ Dosage _____ Time _____ Dosage _____
 Time _____ Dosage _____ Time _____ Dosage _____

Med. #2 _____ Reason for taking _____ Side effects: _____
 Time _____ Dosage _____ Time _____ Dosage _____
 Time _____ Dosage _____ Time _____ Dosage _____

Med. #3 _____ Reason for taking _____ Side effects: _____
 Time _____ Dosage _____ Time _____ Dosage _____
 Time _____ Dosage _____ Time _____ Dosage _____

Family Physician's name _____ Phone _____

Family Dentist/Orthodontist's name _____ Phone _____