

Red Wing Family YMCA Camp Pepin Health Form

For staff use only at check-in:

These initials indicate that the information on this form is current when the participant named below checks into camp.

THE FOLLOWING INFORMATION MUST BE COMPLETED BY AN ADULT 18 YEARS OF AGE OR OLDER.

The intent of the completed information in this Health Form is to provide camp health care personnel the background to administer appropriate care to the participant named below while he or she is attending camp. Any changes to this form should be provided to camp health care personnel upon the participant's arrival.

Personal Information

Name of Participant: _____ Birth Date: _____ Age at Camp: _____

Gender (Male/Female): _____ The participant will be a (Camper/Staff Member/Volunteer): _____

Current Address: _____

Permanent Address: _____

Current Phone: _____ Permanent Phone: _____

Custodial Parent/Guardian (if under 18): _____ Relation: _____

Parent's/Guardian's Home Address (if different from above): _____

Parent's/Guardian's Home Phone (if different from above): _____

Parent's/Guardian's Business Name and Phone: _____

2nd Custodial Parent/Guardian (if applicable): _____ Relation: _____

2nd Parent's/Guardian's Address (if different from above): _____

2nd Parent's/Guardian's Phone (if different from above): _____

2nd Parent's/Guardian's Business Name and Phone: _____

In an emergency, if no parent or guardian is available, please contact:

Name: _____ Relation: _____ Phone: _____

Address: _____

Insurance Information

Is the participant covered by family medical/hospital insurance? (Yes/No): _____

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

Name of Policy Holder: _____ Relation to Participant: _____

Social Security # or Insurance ID # of Policy Holder: _____

Medical Provider Information

Name of Family Physician: _____ Phone: _____

Address: _____

Name of Family Dentist/Orthodontist: _____ Phone: _____

Address: _____

Health History

Circle "Yes" or "No."

- | | | | | | |
|---|-----|----|--|-----|----|
| 1. Had a recent injury, illness or disease? | Yes | No | 16. Ever had high blood pressure? | Yes | No |
| 2. Have a chronic illness or condition? | Yes | No | 17. Ever had back problems? | Yes | No |
| 3. Ever been hospitalized? | Yes | No | 18. Ever had arthritic problems? | Yes | No |
| 4. Ever had surgery? | Yes | No | 19. Have an orthodontic appliance? | Yes | No |
| 5. Have frequent sinus infections? | Yes | No | 20. Have any skin problems? | Yes | No |
| 6. Have frequent headaches? | Yes | No | 21. Have diabetes? | Yes | No |
| 7. Ever had a head injury? | Yes | No | 22. Have asthma? | Yes | No |
| 8. Ever been knocked unconscious? | Yes | No | 23. Had mononucleosis in the past 12 months? | Yes | No |
| 9. Have frequent stomach upsets? | Yes | No | 24. Had problems with diarrhea? | Yes | No |
| 10. Wear glasses or contacts? | Yes | No | 25. Had problems with constipation? | Yes | No |
| 11. Have frequent ear infections? | Yes | No | 26. Have problems with sleepwalking? | Yes | No |
| 12. Ever been dizzy during/after exercise? | Yes | No | 27. If female, have abnormal menstruation? | Yes | No |
| 13. Ever passed out during/after exercise? | Yes | No | 28. Have a history of bed-wetting? | Yes | No |
| 14. Ever had a seizure? | Yes | No | 29. Ever had an eating disorder? | Yes | No |
| 15. Ever had heart problems? | Yes | No | 30. Ever had emotional difficulties? | Yes | No |

Explain any "Yes" answers, noting the number of the question.

Dietary Restrictions

List any specific dietary limitations (e.g., does not eat red meat, pork, seafood, poultry, eggs, dairy products, etc.).

Allergies

List all known.

Type of allergy	Possible reaction	Care for reaction

Medications

List all medications, including over-the-counter drugs taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original container that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration. The administration of medications will be followed according to what is prescribed on the medication bottle; if there are any changes to this, a signed physician's note stating these changes must accompany the medication.

_____The participant takes no medications on a routine basis.

_____The participant takes medications routinely as follows: (If more space is needed, list the information below on a separate sheet.)

Medication	Dosage	Specific time(s) of day	Reason for taking

Attach another page for additional medication.

Immunizations

Provide immunization dates (Mo/Yr) for the following vaccines:

Hepatitis B	_____	_____	_____	_____	_____
Haemophilus infl. B (Hib)	_____	_____	_____	_____	_____
DTP	_____	_____	_____	_____	_____
TD	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____
Varicella (chicken pox)	_____	_____	_____	_____	_____
Other:_____	_____	_____	_____	_____	_____

Physical Restrictions

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

Authorization

IMPORTANT: THE FOLLOWING MUST BE COMPLETE TO ATTEND CAMP!

This health history is correct and complete to the best of my knowledge. I hereby give permission to the camp personnel to provide routine health care for the participant. In case of a life or death emergency, I hereby give permission to the physician/facility selected by the camp personnel to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for the participant in the event that the participant cannot make the decision on his or her own. The camp and its employed personnel shall be relieved of any responsibility. This completed form may be photocopied for trips off of the camp property.

Signature of Camper's Parent/Guardian, *Staff Member, or Volunteer Date

*Signature of Parent/Guardian for Staff Members under 18 yrs of age Date

Red Wing Family YMCA Camp Pepin Health Form (Physician's Section)

THE FOLLOWING INFORMATION MUST BE COMPLETED BY A LICENSED PHYSICIAN.

Note to the Physician

The participant named below will soon be attending YMCA Camp Pepin. Because of the nature of the camp atmosphere, the participant may undergo much physical activity in an outdoor setting. The intent of the completed information in this Health Form is to provide camp health care personnel the background to administer appropriate care to the participant named below while he or she is attending camp.

Personal Information

Name of Participant: _____ Birth Date: _____ Age at Camp: _____

Gender (Male/Female): _____ The participant will be a (Camper/Staff Member/Volunteer): _____

Height: _____ Weight: _____ Blood Pressure: _____

Physician's Information

Printed Name of Physician: _____ Phone: _____

Clinic/Health Care Facility: _____

Address: _____

Date of most recent examination: _____

Physician's Recommendation

Is the above named participant able to participate in an active camp program? _____ Yes _____ No

Explain any restrictions to camp activity (e.g. what cannot be done, what adaptations are necessary), and any treatments or medications that need to be continued at camp.

Authorization

As a licensed physician, I verify that the participant named above has been examined and that the completed information in this Health Form has been reviewed. This completed form may be photocopied for trips off of the camp property.

Signature of Licensed Physician

Date