YMCA CAMP SILVER CREEK

FOR YOUTH DEVELOPMENT® FOR HEALTHY LIVING FOR SOCIAL RESPONSIBILITY

Session(s) Attending _____

Camp Staff Use Only
(Please Indicate Unit)

☐ Bear Creek ☐ Hemlock
☐ Hillside ☐ LIT
☐ Trickle Falls ☐ Staff

HEALTH HISTORY FORM / PARENT PERMISSION FORM DUE JUNE 1

Any changes to this form should be provided in writing upon participant's arrival at camp. Please provide complete information so that the camp is aware of participant's needs.

Last Name: _____ First Name: _____ Nickname:_____

Gender: _____ Date of Birth: _____/_____/_____ Grade (upcoming school year): _____ Age as of June 1: _____

Parent/Guardian Name_____ Cell # (____)_____-_____ Alternate # (____)_____-_____

Parent/Guardian Name_____ Cell # (____)_____-_____ Alternate # (____)_____-_____

Home Address_____ City_____ State_____ Zip_____

Emergency Contact 1_____ Relationship_____ Cell # (____)_____-_____ Alternate # (____)_____-____

Emergency Contact 2_____ Relationship_____ Cell # (____)_____-_____ Alternate # (____)_____-____

Parent/guardian will be contacted first in an emergency. If parent/guardian is unreachable, emergency contacts will be called.

MEDICAL INFORMATION

Name of family physician: _____ Phone (____)_____-_____

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

ALLERGIES: LIST ALL KNOWN (Medications, food, environmental, etc.)

Food Allergy: ☐Dairy ☐Soy ☐Eggs ☐Peanuts ☐Tree Nuts ☐Fish ☐Shellfish ☐Wheat Other: _____

Allergy	Check all the apply	Describe the reaction, severity, and a preferred response:
_____	☐airborne / ☐ ingested / ☐contact	_____
_____	☐airborne / ☐ ingested / ☐contact	_____
_____	☐airborne / ☐ ingested / ☐contact	_____
_____	☐airborne / ☐ ingested / ☐contact	_____

Diet Accommodations: **Please Complete if your child has a food allergy or special diet and provide more information below.**

Special Diet: ☐Vegetarian ☐Vegan ☐Gluten (Celiac) ☐Gluten Sensitivity ☐Lactose

Please explain any other special diet needs or restrictions:

PRESCRIPTION MEDICATIONS

Does the participant take prescription medication: ☐ Yes ☐ No *If yes, please note the following instructions:*

Deliver any medications to Health Staff at check-in.

- Send in original prescription bottle and only enough for the length of camp, plus one day. Please send all medications the camp participant takes at home
- Our on-site Health Center Staff collects and dispenses all prescription medications. **No medications are allowed with participant or in living unit**

Medication: _____ Dose: _____ Frequency: _____ Administration: B ☐ L ☐ D ☐ Bed ☐

Medication: _____ Dose: _____ Frequency: _____ Administration: ☐☐☐☐

Medication: _____ Dose: _____ Frequency: _____ Administration: ☐☐☐☐

Does your child carry an epi-pen? ☐ Yes ☐ No Reason: _____

NON-PRESCRIPTION MEDICATIONS

Camp Staff will monitor the day to day needs of campers and may administer non-prescription medications, per package instructions in the case of illness or injury.

I authorize the following non-prescription medications to be administered to participant by the camp health care provider as needed. _____ (INITIAL HERE)

Acetaminophen (Tylenol)	Bismuth Subsalicylate (Pepto-Bismol)	Antacid
Ibuprofen (Advil)	Cough Syrup/Sore Throat Spray	Cough Drops/Throat Lozenge
Loratadine (Claritin)	Benadryl	Anti-Itch Cream

(If applicable):

Has camper begun menstruation? ☐Yes ☐No If not, have they been told about it? ☐ Yes ☐ No

MEDICAL INFORMATION PAGE 2 Last Name:_____ First Name:_____

PLEASE NOTE: If your participant has special health needs (including but not limited to diabetes, cardiac illness, severe asthma, seizures, serious behavioral issues, or severe allergies), you must contact the Camp Director for advance clearance. On a case-by-case basis, we consult with parent/ guardian and our camp health care provider to determine if accommodation and appropriate care is available.

PLEASE CHECK ALL BOXES *(a response is needed for each)*

Asthma	☐Yes	☐No	Frequent Ear Infections	☐Yes	☐No	HIV or AIDS	☐Yes	☐ No
Migraines	☐Yes	☐No	Sleep Walking	☐Yes	☐No	ADD/ADHD	☐Yes	☐ No
Bedwetting	☐Yes	☐No	Cardiac Defect/Disease	☐Yes	☐No	Bleeding/Clotting Problems	☐Yes	☐ No
Diabetes	☐Yes	☐No	Epilepsy or Seizures	☐Yes	☐No	Crohn's Disease	☐Yes	☐ No
Fainting	☐Yes	☐No	Hepatitis	☐Yes	☐No	Conditions Not Listed	☐Yes*	☐ No

*Please describe_____

1. Describe any other significant PAST medical treatment or history.

2. Describe any CURRENT physical, developments, or psychological conditions requiring medication, treatment, special restrictions, or considerations while at camp.

3. Describe what camp activities from which the participant should be exempt for health or developmental reasons.

4. If the participant is currently under the care of a physician for any conditions, please provide a brief explanation of the treatment.

IMMUNIZATION HISTORY

Is the participant current with all school required immunizations? ☐Yes ☐No *If not, please attach a completed waiver form.*

Is Tetanus immunization current? ☐Yes (month/year, if known) _____ ☐No

INSURANCE INFORMATION

Please attach health insurance information OR complete below questions. (Helpful at clinic or hospital for any medical treatment.)

☐ **Self-pay / No Insurance at this time** (Please indicate name and address of person responsible for payment)

Name: _____

Address: _____

☐ **Private Insurance**

Insurance Company: _____

Policy #: _____ Policy Holder's Birthdate: _____ / _____ / _____

Name of Insured: _____ Relationship to participant: _____

This health history is accurate so far as I know and the above stated person has my permission to visit and participate in all activities, except as noted above, at YMCA Camp Silver Creek. I hereby give permission for the camp staff to provide routine health care, administer prescribed and nonprescription medication, arrange necessary transportation, seek emergency medical treatment, including X-rays, routine tests, injections and/or anesthesia and/or surgery, for camper named above. I understand all precautions will be taken for camper care and supervision. I entrust care of my child to camp staff during their visit. Beyond this I will not hold camp staff, Camp Silver Creek or the YMCA responsible or liable.

Parent/Guardian Signature: _____ Date: _____

Camp Use Only - Reviewer's Initials: _____ (Camp Health Care Provider) _____ (Infirmary Staff) _____ (Counselor)