

2010 METROWEST YMCA DAY CAMP HEALTH HISTORY AND EXAMINATION FORM

THIS FORM MUST BE COMPLETED BY BOTH THE PARENT/GUARDIAN AND A PHYSICIAN. PAGE ONE OF THE HEALTH FORM MUST BE COMPLETED AND SIGNED BY A PARENT. PAGE TWO OF THIS HEALTH FORM MUST BE COMPLETED AND SIGNED BY A PHYSICIAN. A PHYSICIAN FORM MAY BE ATTACHED TO THIS FORM INSTEAD OF PAGE 2.

CAMPER NAME		SESSIONS ATTENDING	Please circle 1 2 3 4 SW
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Camper _____ Birth Date _____ Sex ___ Age _____
 Home Address _____ Phone _____
Street City Zip

Custodial parent/guardian _____ Phone _____
 Home Address _____ Cell Phone _____
 Business Address _____ Phone _____

Second parent or guardian _____ Phone _____
 Home Address _____ Cell Phone _____
 Business Address _____ Phone _____

If not available in an emergency, notify: 1) _____ 2) _____
 1) Relationship: _____ Phone _____
 2) Relationship: _____ Phone _____

Health history (Yes/No; give dates if applicable)

Frequent Ear Infections	Chicken Pox	Hay Fever
Heart Defect / Disease	Measles	Poison Ivy
Convulsions	German Measles	Insect Stings
Diabetes	Mumps	
Bleeding/Clotting Disorders		

Operations or serious injuries (Dates) _____
Chronic or recurring illness _____
Drug/Food Allergies _____
Name of dentist/orthodontist _____ Phone _____
Name of child's physician _____ Phone _____
Do you carry family medical/hospital insurance? _____ If so, please indicate:
 Carrier _____ Policy or Group # _____
Is there any other additional information for health care staff at the camp? _____

Important— Must be completed for Attendance

Parent/Guardian Authorization: This health history is correct and complete as far as I know. The child herein described has permission to engage in all camp activities except as noted by me and the examining physician.
 I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including transportation, ordering x-rays and routine tests. 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. I also give permission to photocopy this form to bring along on camper field trips.

Signature _____ **Date** _____

Please notify the camp nurse if this camper is exposed to any communicable disease during the three weeks prior to her or his camp attendance.
**If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

**This side is to be filled out by a licensed physician
or you may attach the physician's own form.**

Camper's Name _____

Immunization History please record all dates (month and year) of immunizations and most recent booster doses.

Date of last physical exam: _____

must be within 24 months of child's attendance at camp.

Height _____ Weight _____ Blood Pressure _____

VACCINES	Month/Yr	Month/Yr	Month/Yr	Month/Yr	Month/Yr
DPT <small>Diphtheria, Pertussis, Tetanus</small>					
TD <small>Tetanus, Diphtheria</small>					
Tetanus					
Polio					
MMR <small>Measles, Mumps, Rubella</small>					
Measles, 2nd shot required					
Chicken Pox					
Tuberculin Test					
HB (Haemophilus influenza)					
Hepatitis B					
Other					

Is the applicant currently under the care of a physician? If yes, why. _____

Allergies (food, drugs, insects, etc.) _____

Child's reaction/treatment to above _____

Current medications: _____

If a camper will be taking medication during the camp day, a medication order (located in the parent packet) must be completed and signed by the physician. A parent must bring the medication to the camp nurse in the original container with doctor's prescription on it.

Recommendations and/or restrictions while in camp:

Dietary _____

Swimming _____

Strenuous Activity _____

Physical, mental, or psychological conditions requiring medication, treatment, or special considerations while at camp _____

I have examined the child herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in all camp activities, unless otherwise noted above.

Licensed Physicians Signature: _____

Address _____ Phone _____

Date of Form Completion _____

For Camp Use Only

Date Screened: _____ Screened By: _____

Additional Notes: _____
