



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

DO NOT MAIL
PLEASE BRING FORM TO
CAMP ON CHECK-IN DAY

YMCA CAMPER HEALTH HISTORY FORM

Camper Name: _____ Birth Date: ____/____/____ Age: _____ Sex: _____
 (Last) (First)
 Address: _____ City: _____ State: _____ Zip: _____ Phone: _____
 Home
 Parent/Guardian 1 Name: _____ Work: _____ Cell: _____
 Parent/Guardian 2 Name: _____ Work: _____ Cell: _____
 Family Email Address: _____
 Emergency Contact Name: _____ Phone: _____ Cell: _____

Immunization History Are all immunizations up to date? Yes No Date of last tetanus shot (if known): ____/____/____

Medical Information

Family Physician: _____ Phone: _____ Date of last physical exam: ____/____/____
 Medical Insurance Carrier: _____ Policy and/or group #: _____

Past or Present (please check). If YES for asterisk * items, must have a Doctor's Authorization completed (reverse side)

Currently under Dr. care* <input type="checkbox"/> Yes <input type="checkbox"/> No	ADD/ADHD <input type="checkbox"/> Yes <input type="checkbox"/> No	Head Lice (recent) <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart defect/disease* <input type="checkbox"/> Yes <input type="checkbox"/> No	Autism <input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No
Recent hospitalization* <input type="checkbox"/> Yes <input type="checkbox"/> No	Asperger's Syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No	Measles <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma* <input type="checkbox"/> Yes <input type="checkbox"/> No	Bedwetting <input type="checkbox"/> Yes <input type="checkbox"/> No	German Measles <input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures* <input type="checkbox"/> Yes <input type="checkbox"/> No	Sleepwalking <input type="checkbox"/> Yes <input type="checkbox"/> No	Other diseases/conditions <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes* <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No	

For each Yes, please explain: _____

Allergies: Bee Stings <input type="checkbox"/> Yes <input type="checkbox"/> No require epi pen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Food Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No List _____	Poison Oak/Ivy <input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No
Other insect/animals <input type="checkbox"/> Yes <input type="checkbox"/> No List _____	Any airborne allergies <input type="checkbox"/> Yes <input type="checkbox"/> No List _____	Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No List _____

Dietary Restrictions? Yes No _____

Any current to restrict full activity including swimming, long hikes, strenuous physical games? Yes No
 Any current mental, or psychological conditions requiring special consideration or restrictions? Yes No

For each Yes, please explain: _____

Current medications: to be continued at camp: *(use additional pages if necessary)*

Med Name, Dosage _____ (Circle frequency) Breakfast, Lunch, Dinner, Bedtime, As needed, Other time _____
 Med Name, Dosage _____ (Circle frequency) Breakfast, Lunch, Dinner, Bedtime, As needed, Other time _____
 Med Name, Dosage _____ (Circle frequency) Breakfast, Lunch, Dinner, Bedtime, As needed, Other time _____
 Med Name, Dosage _____ (Circle frequency) Breakfast, Lunch, Dinner, Bedtime, As needed, Other time _____

Inhalers or Epi pens brought to camp? List what for and instructions _____

Other Medication Instructions for Health Care Staff: _____

Non-Prescription Medications I authorize the following medications or generic equivalent to be administered as needed:

Cough/Sore throat Drops <input type="checkbox"/> Yes <input type="checkbox"/> No	Metamucil <input type="checkbox"/> Yes <input type="checkbox"/> No	Pepto Bismol <input type="checkbox"/> Yes <input type="checkbox"/> No	Cough Syrup <input type="checkbox"/> Yes <input type="checkbox"/> No
Acetaminophen (Tylenol) <input type="checkbox"/> Yes <input type="checkbox"/> No	Benadryl <input type="checkbox"/> Yes <input type="checkbox"/> No	Ibuprofen (Advil) <input type="checkbox"/> Yes <input type="checkbox"/> No	Hydrocortisone <input type="checkbox"/> Yes <input type="checkbox"/> No

Ethnicity (for statistical reporting only) Black/African American Asian/Pacific Islander Hispanic/Latino
 White/Caucasian Native American Other: _____

Waiver of Liability: I, the undersigned parent/person having legal custody/guardianship of the above said minor, give permission for the minor to participate in the YMCA program described above. The minor is physically able and mentally prepared to participate in all activities as described in the announcement for the program. In consideration of said minor being permitted to enter any branch of YMCA of San Diego County ("YMCA") for observation, use of facilities and/or equipment, or participation of the above or any program, I, on behalf of myself (as parent, guardian, coach, aide, spectator or participant) hereby: 1. Acknowledge that (i) I have read this document, (ii) I have had the opportunity to inspect the YMCA facilities and equipment, (iii) I accept them as being safe and reasonably suited for the purposes intended and (iv) I voluntarily sign this document. 2. Release YMCA, its directors, officers, employees and volunteers (collectively "Releasees") from all liability to me for any loss or damage to property or injury or death to person, whether caused by Releasees or otherwise and while such minor is in or near any YMCA branch. 3. I agree not to sue Releasees for any loss, damage, injury or death described above and I will indemnify and hold harmless Releasees and each of them from any loss, liability, damage or cost they may incur due to said minor's presence in, upon or near the YMCA branch; whether caused by the negligence of Releasees. 4. I assume full responsibility for, and risk of, bodily injury, death or property damage due to the negligence of Releasees or otherwise. 5. I do hereby authorize the YMCA as agent for the undersigned, to consent with respect to said minor, to any x-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under general or special supervision of, any physician and surgeon licensed under the provisions of the California Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of the physician or at the hospital. I understand that the YMCA is not responsible for costs incurred for medical care. I intend this document to be as broad and inclusive as is permitted by the laws of the State of California; if any portion hereof is held invalid, I agree the balance shall continue in full force and effect.

Photo Release: I give my permission to the YMCA of San Diego County to use my child's picture or other likeness in any of the YMCA's general publicity and campaign materials.
Luggage Search: I agree that any camp participant's belongings may be searched outside the participant's presence for drugs, alcohol, weapons or other forbidden objects.

Signature of Parent/Guardian: _____ **Date:** ____/____/____



THIS SECTION TO BE COMPLETED IF CURRENTLY UNDER DOCTOR'S CARE OR *ASTERISK-HEALTH CONDITION IS CHECKED ON FRONT OF THIS FORM.

Note: A Doctor's written authorization is only required if the camper has a history of Asthma, Heart Defect/Disease, Seizures, Diabetes, has been recently hospitalized, or is currently under a Doctor's care. If so, complete this section.

Health Examination by Licensed Physician

Child's Name: _____ Birth Date: ___/___/___ Sex: _____

Parent's name: _____

Because of this camper's medical history, we have asked that your written authorization be provided prior to their attendance at YMCA Camp. Please realize that camp is held at either mountain (4300 feet elevation) or oceanfront settings. The programs are very active with strenuous hiking, games, swimming, and camp activities. Your careful consideration is appreciated.

I have examined the child named on this form within the past two years. Date examined: ___/___/___

After examination and my review of his/her health history, it is my opinion that this person is physically able to engage in camp activities, except as noted below.

Height: _____ Weight: _____ Blood pressure: _____

Is the applicant under the care of a physician for any conditions? Yes No Please explain: _____

Any specific activities to be encouraged or limited by physician's advice? _____

Any medically prescribed meal plan or dietary restrictions? _____

Any treatment or medications to be continued at camp (please give specific dosages)? _____

Any allergies? (Food, drugs, plants, insects, etc): _____

Additional health information: _____

Licensed physician signature: _____ Date: ___/___/___

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Date of form completion: ___/___/___ By: _____

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