the YMCA

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 2012

Camper Name:_____ Birth Date:____/____/____ Age:_____ Sex:_____
(Last) (First)

Address:_____ City:_____ State:_____ Zip:_____ Home Phone: _____

Parent/Guardian 1Name:_____ Work:_____ Cell:_____

Parent/Guardian 2Name:_____ 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*	☐ Yes ☐ No	ADD/ADHD	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No
Heart defect/disease*	☐ Yes ☐ No	Autism	☐ Yes ☐ No	Measles	☐ Yes ☐ No
Recent hospitalization*	☐ Yes ☐ No	Asperger's Syndrome	☐ Yes ☐ No	German Measles	☐ Yes ☐ No
Asthma*	☐ Yes ☐ No	Bedwetting	☐ Yes ☐ No	Other diseases/conditions	☐ Yes ☐ No
Seizures*	☐ Yes ☐ No	Sleepwalking	☐ Yes ☐ No	_____	
Diabetes*	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	_____	

For each ✓ Yes, please explain:_____

Allergies

Hay fever	☐ Yes ☐ No	Bee stings	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No
Oak/Ivy poisoning	☐ Yes ☐ No	(Require bee-sting kit)	☐ Yes ☐ No	Other drugs	☐ Yes ☐ No
Foods	☐ Yes ☐ No	Other insects or animals	☐ Yes ☐ No	Any other allergies?	☐ Yes ☐ No

Current medications to be continued at camp (dosage/frequency): _____
_____

Dietary restrictions? ☐ Yes ☐ No
Any reason 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:_____
_____

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

Acetaminophen	☐ Yes ☐ No	Hydrocortizone	☐ Yes ☐ No	Pepto Bismol	☐ Yes ☐ No	Benadryl	☐ Yes ☐ No
Chloraseptic	☐ Yes ☐ No	Cough Drops	☐ Yes ☐ No	Ibuprofen (Advil)	☐ Yes ☐ No	Cough Syrup	☐ Yes ☐ No

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 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 form continued on back.

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:_____

YMCA Overnight Camps Marston | Raintree | Surf
PO Box 2440
Julian, CA 92036
(P) 760.765.0642 (F) 760.765.0183
(E) camp@ymca.org (W) http://camp.ymca.org