

Health History Form

Camp(s) Attending: _____
 Session(s) Attending: _____

Health History Forms must be filled out by a parent/guardian. All day campers, please complete pages 1-3; not all day campers need to complete page 4. For Camp Frank A. Day campers, Camp Pikati campers attending soccer, basketball, baseball, lacrosse, flag football, tennis and/or golf camp, and Camp Chickami campers planning on attending an overnight at Camp Frank A. Day, please complete pages 1-4. Incomplete or unsigned forms will be returned to you.

Please return the completed health history form and other documentation via email: campingservices@westsuburbanymca.org,
 Fax: 617-321-2267
 or mail: West Suburban YMCA,
 Attn: Camping Services Registrar
 276 Church St, Newton, MA 02458

In addition to this completed form, the following must be submitted in order to complete your camper's health record:
Any missing pieces will delay processing.

- This health history form (including required signature on page 3)
- Certificate of immunizations signed by a licensed health care provider
- Photocopy of front and back of insurance card
- Please keep a copy of the completed form for your records

CONTACT INFORMATION

Camper's Name: _____ Birth Date: ____/____/____

Current Grade : ____ Grade for Fall: ____ Age (as of start of camp) ____ Gender: Male Female

Street Address: _____

City: _____ State: _____ Zip _____

Home Phone: _____

Parent/Guardian #1 Name: _____ Parent/Guardian #2 Name: _____

Address: _____ Address: _____

Work Phone: _____ Work Phone: _____

Cell Phone / Pager: _____ Cell Phone / Pager: _____

Email: _____ Email: _____

If the parent/guardian will be travelling during your child's time at camp, please provide the travel location and phone number:

IT IS REQUIRED THAT YOU LIST 2 CONTACTS IN ADDITION TO THE PARENTS LISTED ABOVE:

The following individuals are authorized to pick-up the camper from camp and should be contacted in the event of an emergency if the parent cannot be reached:

Emergency Contact #1 Name: _____ Emergency Contact #2 Name: _____

Relationship to Camper: _____ Relationship to Camper: _____

Daytime Phone: _____ Daytime Phone: _____

Cell Phone / Pager: _____ Cell Phone / Pager: _____

Email: _____ Email: _____

Camper's Physician Name: _____ Phone: _____

Address: _____

Camper's Dentist/Orthodontist Name: _____ Phone: _____

Address: _____

Insurance Information:

Is the camper covered by family medical/hospital insurance? NO YES (Please complete the remainder of this section.)

Carrier or Plan Name: _____ Group or Policy Number: _____

Special Instructions: _____

MEDICAL HISTORY

The following information must be filled in by the parent/guardian. This information is intended to provide camp health care personnel with the background to provide appropriate care. Please keep a copy of the completed form for your records. Any changes to this form should be provided to the camp health personnel upon the camper's arrival to camp. Complete information must be provided so that the camp may be aware of your camper's needs.

If "NONE" please indicate that clearly below—do not leave blank.

ALLERGIES List all known.

Medication allergies NONE

Describe reaction and management of the reaction:

Food allergies NONE

Describe reaction and management of the reaction:

Other allergies NONE

Include insect stings, hay fever, asthma, animal dander, etc.:

MEDICATIONS

Please list ALL medications, including over-the-counter or nonprescription drugs taken routinely. Bring enough medication to last the entire time at camp. Medication must be in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration. All medications must be given to the camp nurse or health care supervisor on the first day at check-in.

NONE

As of ____/____/2010, this person takes the following medications:

Name of medication	Date started	Reason for taking it	When it is given	Amount/dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other: _____		

Identify any medication taken during the school year that the participant does/may not take during the summer: _____

RESTRICTIONS

Explain any limitations to activity (e.g. what cannot be done at all or what adaptations are necessary for participation): NONE

Camper does not eat: red meat pork poultry seafood eggs dairy product nuts & nut products
 other: _____

PLEASE NOTE:

Only campers attending Camp Frank A. Day, Camp Pikati campers attending soccer, basketball, baseball, lacrosse, flag football, tennis and/or golf camp, and Camp Chickami campers attending an overnight at Camp Frank A. Day need to complete this page. It is acceptable to attach a doctor's form here and write "see attached" for this page, if you do not have this form with you at the time of your doctor's appointment.

PHYSICAL EXAMINATION BY A LICENSED HEALTH CARE PROVIDER

I examined this individual on ____/____/20____. (Date must be no sooner than August 1, 2009.)

BP _____ Weight _____ Height _____ Temp _____

In my opinion, this applicant is is not able to participate in an active camp program.

The applicant is under the care of a physician for the following condition(s): _____

Recommendations and Restrictions at Camp:

Treatment to be continued at camp: _____

Medications to be administered at camp (name, dosage, frequency): _____

Any medically-prescribed meal plan or dietary restrictions: _____

Known allergies: _____

Description of any limitations or restrictions on camp activities: _____

Additional information for health care staff at camp: _____

Signature of Licensed Health Care Provider: _____

Printed Name & Title _____ Today's Date: _____

Address: _____

Phone: _____ Emergency Number: _____

FOR CAMP USE ONLY:

Date screened _____ Session _____ Time _____ am / pm

Medication received _____

Updates/additions to the health history noted Yes No None required

Current health needs identified _____

Observational notes _____

Screened by _____ Date ____/____/2010