

Sessions (office use only):

CAMPER HEALTH FORM

PLEASE RETURN THIS FORM BY JUNE 1 OR AT LEAST 3 WEEKS PRIOR TO ATTENDING CAMP

Mail to: Phantom Lake YMCA Camp

S110W30240 YMCACamp Rd, Mukwonago, WI 53149 OR fax 262-363-4351

The information on this form is gathered to help us provide safe and appropriate health care. All information on this form is confidential and is kept in a separate locked file. It will be reviewed ONLY by the camp nurse, trip staff and/or Camp Administration. This form must be completed and signed by a parent or adult guardian of a camper under age 18.

IMPORTANT—SIGNATURE MUST BE COMPLETED FOR ATTENDANCE**

Permission to Provide Necessary Treatment or Emergency Care:

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted. I hereby give permission to the camp to order X-rays, routine tests, and treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child /me. 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 below. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staffer _____ Date _____

Printed Name _____

**If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

CAMPER SIGNATURE: I also understand and agree to abide by ANY restrictions placed on my camp activities.

Signature of minor or adult camper/staff _____ Date _____

PLEASE PRINT ALL INFORMATION

Camper's Name _____ Birth Date ____ / ____ / ____
Last First Mid Initial

Home Address _____ Gender: M F
Street Address City State Zip

Custodial parent/guardian _____ Home Phone _____
Last First

Cell Phone _____ Work Phone _____

Home Address _____ / _____ / _____
(If different from above) Street Address City State Zip

PLEASE provide names of **TWO** other individuals in case we can not reach you in an emergency!

Name: _____ Relationship _____ Home Phone _____
Last First

Cell Phone _____ Work Phone _____

Address _____ / _____ / _____
Street Address City State Zip

Name: _____ Relationship _____ Home Phone _____
Last First

Cell Phone _____ Work Phone _____

Address _____ / _____ / _____
Street Address City State Zip

INSURANCE INFORMATION (MANDATORY)

➔ **Photocopy of front and back of health insurance card must be attached to this form** ⬅

Is the participant covered by family medical/hospital insurance? YES _____ NO _____

Name of insured _____ Relationship to participant _____ Group # _____

Carrier Name _____ Carrier Address _____

Year 2008

FIRST Name

LAST Name

HEALTH HISTORY

Please provide **COMPLETE INFORMATION**. This helps camp health staff provide safe care to your child.
KEEP A COPY OF THE COMPLETED FORM FOR YOUR RECORDS.

ALLERGIES: List all known. Describe how your child reacts if exposed and how it is treated.

Medication allergies (list)	Reacts	Treated
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1. _____	_____	_____
2. _____	_____	_____

Food Allergies (list) - Please also indicate if the food allergy extends to products with cross-contamination warnings.

1. _____	_____	_____
2. _____	_____	_____

Other Environmental Allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.

1. _____	_____	_____
2. _____	_____	_____

MEDICATIONS:

The following medications are used to treat minor symptoms of illness/injury while your camper is here. All medication indications and dosages are approved by the camp Medical Advisor. Please **CROSS OUT** below any medications listed below that **SHOULD NOT** be administered: **A&D ointment, Acetaminophen, Benadryl, Bactine Benzocaine oral gel, Calamine lotion, Cepacol lozenges, Chloraseptic lozenges, Dimetapp, Claritin, Tums, EpiPen auto-injector, Bausch and Lomb eye-wash, Hydrocortisone cream, Ibuprofen (Advil, Motrin, Nuprin), Imodium AD, Kaopectate, Milk of magnesia, Pepto-Bismol, Robitussin Cough Syrup, Sudafed, Swimmer's ear-drops, Triple Antibiotic Ointment, Visine Eye Drops.**

Does your child take medication on a regular basis?

____ **NO**, my child takes NO medications on a routine basis. I give permission for the above over the counter medications listed above to be used by the Phantom Lake YMCA Camp Health Staff (with the exception of those crossed out).

____ **YES**, my child takes medication on a routine basis and **WILL be bringing his/her medication to camp.**

IF YES PLEASE COMPLETE ENCLOSED WHITE MEDICATION FORM

____ **YES**, my child takes medication on a routine basis but **WILL NOT be bringing his/her medication to camp.**

IF YES, please indicate below what medications your child takes routinely, the dose, and reason for taking.

Medication	Reason
_____	_____
_____	_____
_____	_____

RESTRICTIONS:

The following restrictions apply to this individual.

Dietary Restrictions:

_____ Does not eat red meat	_____ Does not eat pork	_____ Does not eat eggs
_____ Does not eat poultry	_____ Does not eat seafood	_____ Does not eat dairy products

Other Dietary Needs or Restrictions (describe)

Physical Restrictions:

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

Please indicate with a check if the participant has had any of the following illnesses:

Mumps	_____	Date	_____
German Measles	_____	Date	_____
Chicken Pox	_____	Date	_____
Measles	_____	Date	_____
Mononucleosis	_____	Date	_____

Please attach recent photo of camper here

General Health History (Please explain "yes" answers below)

Has/Does the participant:

		Yes	No			Yes	No
1	Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	14	Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2	Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	15	Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
3	Have any cognitive or developmental conditions/disabilities?	<input type="checkbox"/>	<input type="checkbox"/>	16	Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
4	Have any genetic conditions/disorders?	<input type="checkbox"/>	<input type="checkbox"/>	17	Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
5	Ever been hospitalized? (if YES, indicate date(s) below)	<input type="checkbox"/>	<input type="checkbox"/>	18	Ever had problems with joints (e.g. knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
6	Ever had surgery? (if YES, indicate date(s) below)	<input type="checkbox"/>	<input type="checkbox"/>	19	Have any skin problems (e.g. itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
7	Require additional assistance or an aide while at school?	<input type="checkbox"/>	<input type="checkbox"/>	20	Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
8	Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	21	Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
9	Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	22	Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
10	Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	23	Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
11	Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	24	Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
12	Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	25	Have problems sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>
13	Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26	If female: (a) begun menstruation?	<input type="checkbox"/>	<input type="checkbox"/>
					(b) have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain in detail any YES answers, noting which questions.

BEHAVIORIAL, EMOTIONAL, and SOCIAL HEALTH

- | | | YES | NO |
|----|---|-----|-----|
| 1) | Has the participant had a recent change of living situation?..... | ___ | ___ |
| 2) | Is/Has the participant been under the care of a mental health professional?
(if so, please indicate his/her contact information below) | ___ | ___ |
| 3) | Does the participant take medication(s) for behavioral concerns?..... | ___ | ___ |

Please use this space to clarify any YES answers or to provide PLYC medical staff with any additional information about the participant's behavior and physical, emotional, or mental health. Please be specific for optimum care. If the participant is under care for serious mental health issues, please consult with physician, psychiatrist/psychologist and camp health staff to see if camp is an appropriate setting.

Name of family Psychiatrist/Psychologist _____ Phone _____ Cell Phone _____
 Address _____ / _____ / _____ / _____
 Street Address City State Zip

ADDITIONAL PROFESSIONAL CONTACT INFORMATION

Name of family Physician _____ Phone _____
 Address _____ / _____ / _____ / _____
 Street Address City State Zip

Name of family dentist/orthodontist _____ Phone _____
 Address _____ / _____ / _____ / _____
 Street Address City State Zip

SCREEN RECORD - for camp use only

ALL signatures complete? Emergency Care _____ Health History _____
 Medical Exam Current? _____ Update Signed _____
 Meds ? _____ YES _____ NO If YES: Complete Form? _____ Correct Containers? _____

Current Health Needs Identified? _____

Observational Notes:
