Camper Health Form Camp Y-Owasco

Health History Forms must be filled out by a parent/guardian. Please complete all pages. Incomplete or unsigned forms will be returned to you. Please return the completed forms and other documentation via email: joshua@auburnymca.net, fax: 315-253-6153 or mail to: Auburn YMCA-WEIU 27 William St. Auburn, NY 13021, Attn: Camp Y-Owasco

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)
- ☐ Copy of child's most recent physical exam within the past 12 months OR page 4 of this form filled out by a Licensed health care provider
- ☐ Certificate of immunizations (diphtheria, haemophilus influenza type b, hepatitis b, measles, mumps, poliomyelitis, rubella, tetanus, and varicella) 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

Camper's Name: _____

Camper's Home Address: _____

Birth Date: _____/_____/ Weight: _____ Age: _____

Who has legal custody of the camper? Circle: Both Parent/Guardian 1 Parent/Guardian 2

Parent / Guardian #1 information

First Name Last Name

Street Address

City State Zip

Home Phone

Work Phone

Cell Phone

Email

Parent / Guardian #2 information

First Name Last Name

Street Address (if different from Parent/Guardian1)

City State Zip

Home Phone

Work Phone

Cell Phone

Email

I give permission for my child to carry FDA-approved sunscreen and apply it him/herself. ☐ Yes ☐ No

I give permission for the unlicensed camp staff to apply FDA-approved sunscreen for my child if my child asks for assistance:

☐ Yes ☐ No

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www.y-owasco.org www.auburnymca.org Camp Y-Owasco is a program of the Auburn YMCA

Please list additional contacts, other than parent/guardian**,** that we may contact in the event of an emergency and that are authorized to pick up the camper. **A photo I.D. is required at pick up.**

Name_____ Name_____

Relationship to Camper_____ Relationship to Camper_____

Contact phone number:_____ Contact phone number: _____

Email_____ Email_____

Camper's Physician information:

Name:_____ Phone:_____

Address:_____

Camper's Dentist/Orthodontist information:

Name: _____ Phone: _____

Address: _____

Insurance information:

Is the camper covered by family medical/hospital insurance? ☐ NO ☐ YES

Carrier/Plan Name:_____Group/Policy Number: _____

Camper's 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 arrival. Complete information must be provided to ensure camp is 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 Describe reaction and management of the reaction

_____ _____

Restrictions:

Explain any limitations to activity (i.e. 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 products ☐ nuts & nut products

☐ other:_____

Mental, Emotional and Social health:

Has the camper:

Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?	☐ Yes	☐ No
Ever been treated for emotional or behavioral difficulties or an eating disorder?	☐ Yes	☐ No
During the past 12 months, seen a professional to address mental/emotional health concerns?	☐ Yes	☐ No
Had a significant life event that continues to affect the camper's life?(history of abuse, family change, etc.)	☐ Yes	☐ No

Please explain any YES answers and describe any current physical, mental or psychological conditions requiring medication, treatment or special considerations at camp. Please specify circumstances that you would like to be contacted (i.e. a diabetic who has blood sugar less than 70 or greater than 250) and briefly describe anything we should know about your child such as disabilities, IEP, etc. Feel free to attach another sheet of paper if more room is needed.

Medications:

Please list ALL medications, including over-the-counter or non-prescription 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 health care supervisor on the first day at check-in. **NYS regulations require a copy of physician's order.**

☐ None

☐ As of_____/_____/2018, this person takes the following medications: Identify any medication taken during the school year that the participant does/may not take during the summer:

name of medication	date started	reason for taking	when given	amount /dose	how is it given

Questionaire:

Has/does the camper:

1. Ever been hospitalized?	☐ Yes	☐ No	11. Had fainting or dizziness?	☐ Yes	☐ No
2. Ever had surgery?	☐ Yes	☐ No	12. Passed out/chest pain during exercise?	☐ Yes	☐ No
3. Have recurrent/chronic illnesses?	☐ Yes	☐ No	13. Had mononucleosis during the past year?	☐ Yes	☐ No
4. Had a recent infectious disease?	☐ Yes	☐ No	14. Have problems with menstruation/periods?	☐ Yes	☐ No
5. Had a recent injury?	☐ Yes	☐ No	15. Have problems with sleepwalking?	☐ Yes	☐ No
6. Had asthma/wheezing/short breath	☐ Yes	☐ No	16. Ever had back/joint problems?	☐ Yes	☐ No
7. Have diabetes?	☐ Yes	☐ No	17. Have a history of bed-wetting/urine or bowel accidents?	☐ Yes	☐ No
8. Had seizures?	☐ Yes	☐ No	18. Have problems with diarrhea/constipation?	☐ Yes	☐ No
9. Had headaches?	☐ Yes	☐ No	19. Have any skin problems?	☐ Yes	☐ No
10. Wear glasses/contacts?	☐ Yes	☐ No	20. Traveled outside USA the past 9 mos.?	☐ Yes	☐ No
21. History of allergies/allergy shots	☐ Yes	☐ No	22. history of heart problems	☐ Yes	☐ No

Please explain any YES answers in the following space, noting the number of the question:

Parent/Guardian Authorization

This health history is correct and complete to the best of my knowledge. The person herein described has permission to engage in all camp activities, except noted. I hereby give permission to the camp to provide routine health care, administer prescribed and over-the-counter medications and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I understand that I and/or my insurance company are responsible for the expenses incurred. I give permission to the camp to arrange necessary related transportation for my child. In the event I can not be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for my child. This completed form may be photocopied as needed.

Signature of Parent/Guardian _____

Printed Name _____ **Date Signed** _____

The following non-prescription medications are commonly stocked in the health center office and used on an **as needed basis** to manage illness and injury. **These medications will be given only by the medical staff present at camp by weight based dose or package directions**. **Cross out items that should NOT be given to the camper.**

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Aloe
Hydrocortisone 1%
Dextromethorphan (Tussin)
Diphenhydramine(Benadryl)
Alum-Mag Hydroxide-Simethicone (Maalox)
Calamine lotion
Chloraseptic (sore throat spray)
Generic cough drops
Bismuth subsalicylate (Pepto)
Topical antibiotic cream
Laxatives for constipation (Ex-Lax)
Dextrometh/Guaifenesin (Tussin)
Lice shampoo/Scabies Cream (Nix or Elimite)

Please Note: All campers must submit this page filled out by a licensed physician. 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.

Remember to attach a copy of your child's immunization record and the front and back of your health insurance card.

Physical examination by a licensed health care provider.

I examined this individual on_____/_____/20. BP_____Weight_____Height_____Temperature _____

In my opinion, this individual ☐ 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:

Known allergies:

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

Description of any limitations or restrictions on camp activities:

Any medically-prescribed meal plan or dietary restrictions:

Additional information for health care staff at camp:

Signature of Licensed Health Care Provider:

Printed Name & Title_____Today's Date _____

Address_____

Phone_____Emergency Number _____

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For Camp Use Only:

Session_____Time_____am/pm

Medication received _____

Updates/additions to health history noted:

Screened by:_____Date: _____

MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires that a parent or guardian of campers who attend an overnight children's camp for seven (7) or more consecutive nights, complete and return the following form to the camp.

Check one box and sign below.

☐ My child has had the meningococcal conjugate vaccine (MCV4), for example Menactra or Menveo.

Date received: _____

[Note: The Centers for Disease Control and Prevention (CDC) recommend two doses of MCV4 for all adolescents 11 through 18 years of age: the first dose at 11 or 12 years of age, with a booster dose at age 16. Adolescents in this age group with HIV infection should get three doses: 2 doses 2 months apart at 11 or 12 years, plus a booster at age 16.

If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, a booster is not needed.]

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will **not** obtain immunization against meningococcal meningitis disease.

Signed:_____ _____
(Parent / Guardian) Date:

Camper's Name:_____ Date of Birth:_____

Mailing Address:_____

Parent/Guardian's E-mail address (optional): _____

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