

**YMCA Camp Horseshoe**  
 Route 2, Box 138 • Parsons, WV 26287 • (304) 478-2481 • www.hi-y.org  
 Health History for Summer Camp Campers and Staff

All signatures must be completed in ink.  
 Do not fax or email.

Today's Date: \_\_\_\_\_  Staff  Workforce Leadership  Teen Entrepreneurship  
 Sr. HI-Y Leadership  Jr. HI-Y Leadership  
 Dates Attending: \_\_\_\_\_  Adventure Camp  YOC Camp

Camper's Name: \_\_\_\_\_ Gender:  Male;  Female  
 Last First Initial

Home Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Age at camp: \_\_\_\_\_ Birth date: \_\_\_\_\_

1st Parent/Guardian's Name Home Phone Work phone Mobile Phone/pager

2nd Parent/Guardian's Name Home Phone Work phone Mobile Phone/pager

Will custodial parent(s) be away from home during camp week?  Yes (contact camp);  No;  adult participant, (not applicable).  
 If custodial parent(s)/guardian cannot be reached, , notify: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone: (\_\_\_\_\_) \_\_\_\_\_ Mobile Phone: (\_\_\_\_\_) \_\_\_\_\_  
 Note: Emergency contacts will usually be called in cases of: persistent fever of 101+; contagious illness; head lice; health center stay over 24 hours; injury/illness requiring care beyond our health center. You will also be contacted in cases of exceptional discipline or homesick situations.

**Allergies:**  No known allergies.  This camper is allergic to  Food  Medicine  The environment (insect stings, hay fever, etc)  
**Please describe below what the camper is allergic to and the reaction seen:**

**Diet, Nutrition:**  Camper eats a regular diet;  Camper eats a vegetarian diet (describe below);  Camper is Lactose Intolerant  
 Camper has special food needs **Please describe any special needs/restrictions below:**

**Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.**  
 Has the camper:  
 1. Y N Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?  
 2. Y N Ever been treated for emotional or behavioral difficulties or an eating disorder?  
 3. Y N During the past 12 months, seen a professional to address mental/emotional health concerns?  
 4. Y N Had a significant life event that continues to affect the camper's life? (history of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others?)

**General Health History Explain "Yes" answers below:**  
 Y N Ear Infections?; Frequency: \_\_\_\_\_ Y N Skin Problems? Y N Seizures?  
 Y N Recurrent/chronic illnesses? Y N Diabetes? Y N Asthma?: \_\_\_ inhaler?; \_\_\_ Nebulizer?  
 Y N Problems with Diarrhea/constipation? Y N Sleepwalking/sleep concerns? Y N Bedwetting?  
 Y N Recent injury? Y N Ever been hospitalized? Y N Headaches/Migraines?; Frequency: \_\_\_  
 Y N Fears/Phobias? \_\_\_\_\_ Y N Had surgery? \_\_\_\_\_  
 Y N Recent infectious disease? Y N Any current health conditions? \_\_\_\_\_  
 Y N Any hearing, cognitive, musculo-skeletal, neurological impairments: \_\_\_\_\_

I have reviewed the program and activities of the camp and feel the camper can participate  without restriction;  with restriction.  
**Comments:**

Session(s):

Last Name, First Name:

**Prescription Medications** *(must be completed by physician & in original container. Bring only enough for camp stay. All medication, including over the counter, vitamins and natural remedies must be checked into the health center.)*

**Attach additional page as needed:**  Takes no medications on routine basis

Name(s) of medications: \_\_\_\_\_

Dosages given: \_\_\_\_\_

Times to be given (usually given at breakfast, lunch, 4:00, dinner or bedtime): \_\_\_\_\_

Duration of treatment: \_\_\_\_\_

Reason for taking: \_\_\_\_\_

Medications begun: \_\_\_\_\_; Date dosage was last changed \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Any other medications child takes during the school year, but not used for camp? (list) \_\_\_\_\_

**Nonprescription Medications** *(must be in original container)*  Takes no medications on routine basis

Nonprescription taken now: \_\_\_\_\_

Dosage, specific times taken each day: \_\_\_\_\_

Reason for taking & any special instructions (attach additional sheet as needed): \_\_\_\_\_

\_\_\_\_\_

**Immunization History: (List most recent applicable dated, Mo/Yr)**

_____ DTaP/Tdap/Tetanus	_____ MMR (or individually)	_____ Varicella (chicken pox),	Had Chicken Pox? Y N
_____ Hepatitis B	_____ Hepatitis A	_____ Haemophilus influenza B	
_____ Pneumococcal (PCV)	_____ Polio (IPV)	_____ Meningococcal meningitis	

Camper's Physician: \_\_\_\_\_ ( ) Dentist/Orthodontist: \_\_\_\_\_ ( )

Date of last physical examination: \_\_\_\_\_ All participants must have had a physical in the last 24 months. Written evidence is not required.

Camper is covered by family medical/hospital insurance?  yes;  no Insurance Co. \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_; Insurance Co. phone number(s): \_\_\_\_\_

Insurance Coverage Subscriber Name (Policy Holder) \_\_\_\_\_ Birth date of Policy Holder: \_\_\_\_\_

Company address for claims: \_\_\_\_\_

**You MUST INCLUDE a copy (both sides) of the most recent insurance/medical card. Please attach it to this form.**

**THE YMCA DOES NOT PROVIDE ACCIDENT/HEALTH INSURANCE.**  
 Please attach a copy (both sides) of your health insurance card (required by our Doctor's Office).

**↓ IMPORTANT—THIS BOX MUST BE COMPLETED FOR ATTENDANCE ↓**

I \_\_\_\_\_ the parent/guardian of \_\_\_\_\_

Give the YMCA permission to:

1. Dispense \_\_\_\_\_ Ibuprofen or, \_\_\_\_\_ Acetaminophen (Tylenol) to camper (check preference). Dosage: \_\_\_\_\_
2. Dispense medication(s) brought to Camp by parent/guardian or prescribed by a physician while in attendance.
3. Without limitation, or obligation, any and all media, including photographs, film footage, or tape recordings, which may include my or my child's image or voice for purposes of art, advertising, education, or promotion, or for any other purpose consistent with the YMCA Mission, and release the camp from any claim or liability to that use. The images become the exclusive property of the YMCA. I waive all rights to inspect &/or approve any text that may be used in conjunction with the media and the use to which it may be applied.
4. Agree to hold harmless the YMCA, its agents, and employees for all claims alleging bodily injury or property damage occurring while the undersigned is a participant at a YMCA sponsored activity on or off the YMCA premises.
5. Give permission for the YMCA to transport the camper as needed.
6. Give permission, as necessary, to search a camper's belongings when the health, well-being, or safety of the camper or others require it.

I support my child's application and participation in this program at YMCA Camp Horseshoe. I certify that my child is amenable to discipline and is free from habits or attitudes that would make him/her an undesirable camper.

**Permission to Provide Necessary Treatment or Emergency Care:** This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the staff about my child's health status.

**Signature of parent or guardian** or adult camper/staff \_\_\_\_\_ Date: \_\_\_\_\_