

# YMCA CAMPER HEALTH HISTORY FORM

(Complete one form per child - BOTH sides - Must be submitted 3 weeks before camper's arrival)  
 2021 W Street, Sacramento, CA 95818 Phone (916) 452-9622 Fax (916) 452-7724  
 www.sacymca.org

Child's Name: \_\_\_\_\_  M  F Age (during camp) \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Grade (next Fall) \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Parent's Name: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Employed by: \_\_\_\_\_ Employed by: \_\_\_\_\_

Occupation: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

### Emergency Information

Alternative persons to be called in case of an emergency:  
 Name Phone Relationship

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Information Required By State Law

Health Insurance Co.: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Family Dentist: \_\_\_\_\_

Phone: \_\_\_\_\_

### Child Release Authorization

List everyone **AUTHORIZED** to pick up child:  
 Name Phone Relationship

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Vaccines (Required for Specialty Camps)

DPT: \_\_\_\_\_ Measles: \_\_\_\_\_

Tetanus: \_\_\_\_\_ Mumps: \_\_\_\_\_

Oral Polio: \_\_\_\_\_ Rubells: \_\_\_\_\_

### Medical Information Past or Present (Please Check)

Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	ADD/ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Defect/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head Lice (recent)	<input type="checkbox"/> Yes <input type="checkbox"/> No	German Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recent Hospitalization	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bed-wetting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Diseases or Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Currently under Dr. care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleepwalking	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

For each  Yes, please explain: \_\_\_\_\_

### Allergies (Please Check)

Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bee Stings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oak/Ivy Poisoning	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bee Sting Kit	<input type="checkbox"/>	Other Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Foods	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other insects or animals	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Current Medications to be continued at camp (dosage/frequency): \_\_\_\_\_

Dietary Restrictions? :  Yes  No \_\_\_\_\_

### Non-Prescription Medications: I authorize the following medications to be administered as needed:

Tylenol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Benadryl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pepto Bismol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neosporin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chloraseptic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cough Drops	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ibuprofen	<input type="checkbox"/> Yes <input type="checkbox"/> No	Calamine Lotion	<input type="checkbox"/> Yes <input type="checkbox"/> No

## PARENT'S AUTHORIZATION

This health history is correct, so far as I know, and the person herein has permission to engage in all prescribed program activities. I give permission to the physician selected by the YMCA to order X-Rays, routine tests, and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the YMCA to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child named above. We recognize that the participant must follow safety instructions, remain in areas designated by staff and refrain from behavior that is harmful to oneself or others. Failure to adhere to program policies will be cause for participant's dismissal without refund of fees. Photos of my child may be used for promotional purposes. This form may be photocopied for use away from the main program site. I authorize the YMCA staff to apply sunscreen to my child's exposed skin, on an as-needed basis.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## MEMO OF UNDERSTANDING

(To be read, understood and signed by Camper and Parent)

We welcome you to our YMCA summer camp program. In order to provide the best possible camp experience for everyone, there are certain rules and policies that have been established for the health and safety of all involved.

1. The camper agrees to abide by the rules and regulations set by the camp for the health, safety and welfare of all campers.
2. Campers are not allowed to smoke, chew tobacco, possess any smoking materials, alcohol or illegal drugs.
3. All medications/prescribed drugs must be kept in the nurse's cabin under the control of the Health Supervisor.
4. Campers are not to possess or use firecrackers or explosives. Campers may not possess weapons of any kind.
5. Willful destruction of property will be the financial responsibility of the camper's parent.
6. Campers may not leave camp property or established boundaries without YMCA staff permission.
7. Continued inappropriate behavior, including threatening, swearing, not following directions, teasing, sexual harassment/intimidation and improper behavior in transportation vehicles, may result in IMMEDIATE DISMISSAL FROM CAMP WITH NO REFUND.
8. The YMCA is not responsible for articles of clothing or personal belongings lost or damaged.

We reserve the right and WILL send ANYONE home (at parents' expense and liability) who violates these rules. It is the responsibility of the parent/guardian to pick up or arrange transportation home for the camper. The camp administrator reserves the right to determine what constitutes a violation of these rules and will enforce them as necessary.

I have read, understood and will abide by the rules as stated above throughout my stay at camp.

Camper's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## Required for Resident Camp: Examination by Physician

**ALL CAMPERS ARE REQUIRED TO HAVE WRITTEN CONFIRMATION OF A HEALTH EXAMINATION WITHIN 24**

**MONTHS OF ATTENDING BEAR VALLEY CAMP.** Camp is held at an outdoor setting, with programs that are very active, including hiking, games, swimming and traditional 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.

Is the applicant under the care of a physician for any conditions?  Yes  No If yes, please explain:

\_\_\_\_\_

Any specific activities to be encouraged or limited by physician's advice?:

\_\_\_\_\_

Any treatment or medications to be continued at camp (please give specific dosages):

\_\_\_\_\_

Additional health information:

\_\_\_\_\_

Licensed Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Form Completion: \_\_\_\_\_ By: \_\_\_\_\_