

**CAMP HEALTH EXAMINATION FORM FOR CHILDREN, YOUTH & ADULTS  
NEW YORK YMCA CAMP**

**DAY CAMP**

Camper Details

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age at camp \_\_\_\_ Sex \_\_\_\_  
Last First Middle Initial

**Current or Recurring Medical Conditions**

e.g. Heart Defect/Disease, Convulsions, Diabetes, Bleeding/Clotting, Asthma, Hypertension, Psychiatric Treatment, ADD/ADHD, Bedwetting

List any current medical conditions (If none then please note this): \_\_\_\_\_  
\_\_\_\_\_

**Dietary Restrictions** (Including food allergies)

List any dietary restrictions (If none then please note this): \_\_\_\_\_  
\_\_\_\_\_

**Health History**

**Allergies**

\_\_\_ Hay Fever                    \_\_\_ Penicillin  
\_\_\_ Ivy Poisoning, etc        \_\_\_ Other Drugs (specify) \_\_\_\_\_  
\_\_\_ Insect Stings              \_\_\_ Other (specify) \_\_\_\_\_

**Diseases** (give approx dates)

\_\_\_ Mumps                      \_\_\_ German Measles  
\_\_\_ Chicken Pox                \_\_\_ Mononucleosis  
\_\_\_ Measles                      \_\_\_ Whooping Cough

List any operations or serious injuries (with dates): \_\_\_\_\_  
\_\_\_\_\_

**FOR ALL PARTICIPANTS  
THIS MUST BE SIGNED OR YOU WILL NOT BE ABLE TO ATTEND CAMP**

**Emergency Authorization**

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted. Permission to Treat: I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult camper/staff

Date

Camper's name: \_\_\_\_\_

Last

First

**Contact Information**

**Contact Information**

Parent or Guardian (or Spouse) \_\_\_\_\_ Relationship \_\_\_\_\_

Home Address \_\_\_\_\_  
 Street Apt.# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Second Parent/Guardian or Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Third Emergency Contact: Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

**For Female**

Has this person menstruated? \_\_\_\_\_ If not, has she been told about it? \_\_\_\_\_

If so, is her menstrual history normal? \_\_\_\_\_

**Family Medical Information**

Name of family physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Name of family dentist \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Name of family orthodontist \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Whose name is the camper under for medical/hospital insurance? (If none then write NONE) \_\_\_\_\_

Carrier \_\_\_\_\_ Policy or group # \_\_\_\_\_

**Immunization Records**

<u>Vaccine</u>	<u>Month/Year</u>	<u>Month/Year</u>	<u>Month/Year</u>	<u>Month/Year</u>
Diphtheria, Pertussis (Whooping Cough), Tetanus (DPT)				
Tetanus, Diphtheria (TD)				
Diphtheria				
Tetanus				
Oral Polio (Sabin) TOPV				
MMR				
Measles (Hard Measles, Red Measles, Rubella)				
Mumps				
Rubella (German measles, 3 day measles)				
Haemophilis Influenza B (HIB)				
Varicella (chicken pox)				
Hepatitis B				
Other				

TB Mantoux Test : Date of last test \_\_\_\_\_

Result (positive or negative) \_\_\_\_\_

Camper's name: \_\_\_\_\_  
Last First

**Health Care Recommendations by Licensed Physician:** To be completed by physician, and signed on page 4

**Note:** Physical exam MUST be completed within 24 months of the campers last day at camp

**Recommendations and Restrictions While at Camp:**

I have examined the above individual on \_\_\_\_\_ (date)

In my opinion, the above applicant  is  is not able to participate in an active camp program. If not, describe limitations

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

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

*Please complete with patient's current regimen for both prescription and non-prescription, scheduled and PRN medications, including vitamins. Any changes prior to camp must be in writing and signed by physician.*

Drug Name	Route	Dosage	Schedule and Indications	Comments

**FOR PARENT/GUARDIAN TO COMPLETE**

List any additional health history concerns/comments including any information about the participant's behavior and physical, emotional, or mental health that the camp should be aware of:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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