

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

McAlister Village (6-12)

Talcott Village (12-15)

Outdoor Adventures

Gymnastics

Volleyball

Judo

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

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:

Reverse side of this form must be completed and signed by physician and parent/guardian.

Camper's name: _____

Last

First

Standard Over the Counter Medications - The following medications are available in the Health Center and will be administered at the discretion of the Health Director only with **physician's order** and **parental permission**. Please complete dosage and schedule for medications which can be given to participant.

Key: **PRN** (if needed) **PO** (taken by mouth) **Topical** (applied to skin) **Q** (every)

Drug Name	Route	Dosage	Schedule	Indications	Comments
Ibuprofen (e.g. Advil, Motrin)	PO (Chewable tabs, pills or liquid)	_____ mg _____ ml	Q _____ hrs	Pain, fever, cold symptoms, toothache, muscle aches	
Acetaminophen (e.g. Tylenol)	PO (Chewable tabs, pills or liquid)	_____ mg _____ ml	Q _____ hrs	Pain, fever, cold symptoms, toothache, muscle aches	
Pseudoephedrine & Ibuprofen (e.g. Advil Cold & Sinus)	PO (pills)	_____ mg	Q _____ hrs	Pain, fever, nasal congestion	
Robitussin	PO (liquid)	_____ ml	Q _____ hrs	Coughs	
Cough drops and Lozenges	PO (lozenges)		Q _____ hrs	Coughs, sore throats	
Diphenhydramine (e.g. Benadryl)	PO / Topical (pills, liquid, or spray)	_____ mg _____ ml	Q _____ hrs	Insect bites, allergies, respiratory allergies	
Pseudoephedrine (e.g. Sudafed)	PO (Chewable tabs, pills or liquid)	_____ mg _____ ml	Q _____ hrs	Nasal/sinus congestion, hay fever, allergies	
Antacid (e.g. Mylanta, Tums)	PO (pills or liquid)	_____ mg _____ ml	Q _____ hrs	Gas, heartburn, indigestion, stomach upset	
Milk of Magnesia	PO (liquid)	_____ ml	At bedtime	Constipation	
Ivy Block and Tecnu	Topical (cream)		Apply _____ times per day	Contact with poison ivy	
Calagel, Calamine and Hydrocortisone	Topical (cream or gel)		Apply _____ times per day	Insect Bites, rash, skin irritation	
Peroxide	Topical (cream or liquid)		Apply _____ times per day	Cuts, scrapes, splinters, blisters	
Bacitracin	Topical (ointment)		Apply _____ times per day	Cuts, scrapes	
Antifungal Cream/Spray	Topical (cream or spray)		Apply _____ times per day	Athletes foot, jock itch	
Cooling Gel and Aloe	Topical (cream or gel)		Apply _____ times per day	Burns, sunburn, wind burn	
Muscle Rub	Topical (cream)		Apply _____ times per day	Minor muscle strains or pains	
Orasol, Ambesol and Abreva	Topical (cream or liquid)		Apply _____ times per day	Oral herpes, cold sores, toothache	
Medicaïne	Topical (liquid)	1 swab	Apply once	Insect stings	
Visine	Optical (liquid)	_____ drops	Apply _____ times per day	Eye strain, eye irritation	
Nix	Topical (liquid)			Head lice	

REQUIRED - Licensed Physician's Signature _____

License # _____ Phone _____

Address: _____

Date _____ By _____

Initial if completed by nurse or physician's assistant

STAMP

REQUIRED - Parental Permission for medications listed above

Signature of Parent/Guardian _____ Date _____