

# 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  
 \_\_\_\_ Other Drugs (specify) \_\_\_\_\_  
 \_\_\_\_ Ivy Poisoning, etc      \_\_\_\_ Insect Stings  
 \_\_\_\_ Animal Allergies (specify) \_\_\_\_\_  
 \_\_\_\_ 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	
Medicine	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
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**REQUIRED - Parental Permission for medications listed above**

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