

Health History
For Schools & Groups

YMCA Willson Outdoor Center
2732 County Road 11
Bellefontaine, OH 43311-9382
1-800-423-0427

Return to Group Leader.
Must be completed in
blue or black ink.

YMCA MISSION:

To serve the whole community through programs expressing Judeo Christian principles that build a healthy spirit, mind and body.

Today's Date: _____ Name of School or Group: _____

Dates Attending: _____ Home Room Teacher (if school): _____

Participants's Name: _____ Age _____ Birth date: _____
Last First Initial Gender: Male Female

Custodial Parent(s)/Guardian: _____ Participant's Soc. Security # _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone: (____) _____ Work Phone: (____) _____

Mobile Phone: (____) _____ Pager/2nd mobile phone: (____) _____

Will custodial parent be away from home during camp time? Yes (contact leader); No; adult participant, (not applicable).

Second Parent/Guardian or Additional Contact: _____ Custodial parent? _____

Address: _____ Relationship to camper _____

Phone: (____) _____ Alt. Phone: (____) _____

If not available in an emergency, notify: _____ Relationship: _____

Address: _____

Phone: (____) _____ Mobile Phone/pager: (____) _____

Do you carry family medical/hospital insurance yes; no Medical Insurance Co. _____

ID# _____ Company address for claims: _____

NOTE: THE YMCA DOES NOT PROVIDE ACCIDENT/HEALTH INSURANCE.

<u>Allergies (list reaction/treatment on separate page):</u>	<u>Health History (attach mgmt plan if applicable)</u>	<u>Date of Disease:</u>
____ Hay Fever	____ Ear Infections; Frequency: _____	____ Chicken Pox
____ Ivy Poisoning	____ Heart Defect/Disease	____ Measles
____ Insect Stings	____ Seizures	____ German Measles
____ Penicillin	____ Depression	____ Mumps
____ Other Drugs _____	____ Diabetes	____ Bleeding Clotting Disorder
____ Asthma	____ Bi-polar disease	____ Hepatitis
____ Vegetarian; Type: _____	____ Hypertension	____ Other Diseases
____ Lactose Intolerant	____ Sleepwalking/sleep concerns	
Foods: _____	____ Bedwetting	Fears/Phobias _____
Other: _____	____ Attention Def. Disorder	
	____ Migraines; Frequency: _____	

Attach additional sheets as necessary to explain conditions/concerns

Nutritional Restrictions: _____

Any current health conditions: _____

Any restriction to activity/mobility limitations: _____

Any impairments (hearing, cognitive, musculo-skeletal, neurological) _____

Surgery or Serious Injuries/Conditions (Date): _____

Disability, Chronic, or Recurring Illness: _____

Additional Suggestions/Information from Parents: _____

Date of last tetanus shot: _____

School/Group:

Last Name, First Name:

Important: Please notify the camp if camper has been exposed to any communicable disease within three weeks prior to Camp start.

All participants must have had a physical in the last 24 months. Written evidence is not required.

Date of last physical examination: _____

Prescription Medications (must be completed by physician & in original container. Bring only enough for camp stay)

Attach additional page as needed:

Takes no medications on routine basis

Name(s) of medications: _____

Dosages given: _____

Times to be taken: _____

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): _____

Professional References:

Phone

Phone:

Physician: _____ (_____) _____ Dentist/Orthodontist: _____ (_____) _____

↓ **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. The right to use, reproduce, assign, and/or distribute photographs, films, videotapes, and sound recordings of myself or my child for use in materials the YMCA may create.
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.

Permission to Provide Necessary Treatment or Emergency Care: 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. This health history is correct and complete as far as I know and the person herein described has permission to engage in all camp activities except as noted:

Signature of parent or guardian or adult camper/staff _____ Date: _____
(**must be signed in ink**, in presence of notary, if notarizing*)

Witness/ Notary Public Signature _____

Sworn before me and subscribed in my presence this ____ day of ____ 20____. My commission expires _____.

I also understand and agree to abide with the restrictions placed on my activities.

Signature of minor or adult camper/staffer _____

If for religious reasons you cannot sign this, please contact the Camp Director at 1-800-423-0427.

*Notarization of this form is not required, except for specific programs. Without notarization, in the event of accident or illness and the parent/guardian cannot be reached by telephone, the child may not be treated or treatment may be delayed. Notarization expedites the process, although treatment may be delayed. Regardless of notarization, the form must be signed in ink. *Your child will be treated in the event of life-threatening conditions.* All reasonable means to contact the parents will be made.