Health History for Schools, Groups and Adults at YMCA Camp Willson

Must be completed in blue or black ink. Do not fax this form

Return to:

Group/Section _____

Last Name, First Name: _____

Today's Date:_____ Group/School Name: _____

Dates attending: _____, 20____ ☐ Youth Participant; ☐ Adult; ☐ Adult Chaperone

Participant's Name:_____ Gender: ☐ Male; ☐ Female
Last First Initial

Home Address_____

City _____ State _____ Zip Code _____ Age at camp:_____ Birth date: _____

1st Emergency Contact's Name Home Phone Work phone Mobile Phone

2nd Emergency Contact's Name Home Phone Work phone Mobile Phone

If Emergency Contacts cannot be reached, notify: _____ Relationship:_____

Phone: (_____)_____ Mobile Phone: (_____)_____

Allergies: ☐ No known allergies. ☐ This camper is allergic to ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc)
Please describe below what the participant is allergic to and the reaction seen:

Diet, Nutrition: ☐ Participant eats a regular diet; ☐ Participant eats a vegetarian diet (describe below); ☐ Participant is Lactose Intolerant
☐ Participant has special food needs **Please describe any special needs/restrictions below:**

General Health History Explain "Yes" answers below:

Y N Ear Infections?; Frequency: _____ Y N Skin Problems? Y N Seizures?
Y N Recurrent/chronic illnesses? Y N Diabetes? Y N Asthma?: ____ inhaler?; ____ Nebulizer?
Y N Problems with Diarrhea/constipation? Y N Sleepwalking/sleep concerns? Y N Ever been hospitalized? (When/Why?)_____
Y N Recent injury? Y N Bedwetting? Y N Headaches/Migraines?; Frequency: _____
Y N Fears/Phobias?_____ Y N Had surgery? (Type & Date)_____
Y N Recent infectious disease? Y N Any current health conditions?_____
Y N Any hearing, cognitive, musculo-skeletal, neurological impairments: _____
I have reviewed the program and activities of the camp and feel the participant can participate ☐ without restriction; ☐ with restriction.
Additional information concerning items listed above (attach additional sheet as necessary):

Medications: List the name, dosage, times given, reason for taking any medications (prescribed or over the counter); ☐ Takes no medication on a regular basis

Health Insurance: Insurance Company _____; ID # _____ Group # _____
Insurance Co. Phone #: _____ Ins. Coverage Subscriber Name (Policy Holder) _____ DOB Policy Holder: _____
Company address for Claims: _____

I, _____ ❑ Self; ❑ parent/guardian of _____ give the YMCA permission to:

1. Without limitation, or obligation, any and all media, including photographs, film footage or tape recordings, which may include me or my child's image or voice for purposes of art, advertising, education , or promotion, or for any other purpose consistent with the YMCA mission, and release the camp from any claim or liability to that use. The images become the exclusive property of the YMCA. I waive all rights to inspect and/or approve any text that may be used in conjunction with the media and the use to which it may be applied.
2. 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.
3. Give permission for the YMCA to transport the participant as needed.
4. Give permission, as necessary, to search a participant's belongings when the health, well-being or safety of the participant or others require it.

Permission to Provide Necessary Treatment or Emergency Care: This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for me/this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my/my child's health record from providers who treat me/my child and these providers may talk with the staff about my/my child's health status.

Legal Representative Signature (signed in ink, in presence of notary, if notarizing: _____ Date: _____
I am the ☐ Participant; ☐ Parent/Guardian of the Participant.

Optional: Witness/Notary Public Signature _____

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