

YMCA Camp Collins Health History Form

Please submit with Registration



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Child's full name _____ Age at camp _____ Birthdate _____ Gender: ☐ M ☐ F

Emergency Contact Information (If parent cannot be reached)

Emergency Contact Name 1: _____ **Relationship:** _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address: _____

Emergency Contact Name 2: _____ **Relationship:** _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address: _____

Insurance Information—Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name _____ Policy# _____

Name of policy holder _____ Relationship to participant _____

Phone number of carrier _____ Birthdate of policy holder _____

Health History—The following information must be filled out by the parent/guardian or adult staff member. We use this data to provide healthcare personnel with background information on the camper/staff and to educate counseling staff on camper needs.

Behavioral, Social, Developmental or other considerations: _____

Allergies: Please check all that apply to the participant.

☐ This participant has no known allergies.

☐ This participant has an allergy to the following foods: _____ Causes anaphylaxis? ☐ Yes ☐ No

Describe the reaction and what is done to manage it: _____

☐ This participant is allergic to the following medications: _____ Causes anaphylaxis? ☐ Yes ☐ No

Describe the reaction and what is done to manage it: _____

☐ This participant is allergic to the following substances: _____ Causes anaphylaxis? ☐ Yes ☐ No

Describe the reaction and what is done to manage it: _____

Diet: Please check all those that apply to participant. We can work with some medically prescribed diets but cannot cater to individual food preferences. Contact the [Camp Office](#) at 503.663.5813 if you have questions regarding the participant's diet while at camp.

☐ Participant eats a regular, varied diet and is prepared to eat a wide range of foods.

☐ Participant is gluten intolerant.

☐ Participant is lactose intolerant.

☐ Participant is a vegetarian.

Type: _____

☐ Participant is a vegan.

☐ Other, please describe: _____

Parent/Guardian Authorization for Health Care: This health history is correct, and the person described has permission to participate in all camp activities except as noted by me on the backside of this form and/or a physician. I attest that all immunizations required for school are up to date. I give permission to the medical personnel selected by YMCA Camp Collins to release any records necessary for insurance purposes and provide or arrange necessary related transportation for myself/my child in the case of a medical emergency. If I cannot be reached in an emergency, I give permission to the physician to secure and administer treatment, including hospitalization, for my child. This completed form may be photocopied. I understand that information about my child's health may be shared on a "need to know" basis with other camp staff.

Signature of custodial parent/guardian or adult staff _____

Date _____

I, _____ understand and agree to abide with any health related restrictions placed on my camp activities.

Camper Name

Signature of minor participant or adult staff _____

Date _____

Chronic Concerns

- ☐ This participant has no chronic health concerns and is capable of full participation in this program.
 ☐ This participant has the following chronic health concerns: (Check all that apply)

☐ Asthma
 ☐ Severe Headaches
 ☐ Sleepwalking
 ☐ Diabetes

☐ Menstrual Cramps
 ☐ Frequent Ear Infections
 ☐ Frequent Colds
 ☐ Bedwetting

☐ Seizure Disorder
 ☐ Surgical History
 ☐ Fainting

☐ Other, please describe:

Please provide information about supportive health care needed for each checked item above:

General Health Questions – Please explain “yes” answers in the space provided below.

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐	10. Ever have back problems?	☐	☐
2. Ever been hospitalized?	☐	☐	11. Ever had problems with joints (ex. knees, ankles)?	☐	☐
3. Ever had a head injury within the last 6 months?	☐	☐	12. Have an orthodontic appliance at camp?	☐	☐
4. Ever been knocked unconscious?	☐	☐	13. Have any skin problems (ex. itching, rash, acne)?	☐	☐
5. Wear glasses, contacts or protective eye wear?	☐	☐	14. Have mononucleosis in the past 12 months?	☐	☐
6. Ever passed out during or after exercise?	☐	☐	15. Had problems with diarrhea/constipation?	☐	☐
7. Ever had chest pains during or after exercise?	☐	☐	16. If female, have an abnormal menstrual history?	☐	☐
8. Has high or low blood pressure?	☐	☐	17. Have an eating disorder?	☐	☐
9. Ever been diagnosed with a heart murmur?	☐	☐	18. Any current physical, mental or psychological conditions requiring professional treatment or additional consideration?	☐	☐

Explain “yes” answers and please note the question number

Name of family physician Phone

Name of family dentist/orthodontist Phone

Which of the following Diseases has the participant had?

Measles Mumps

Chicken pox Hepatitis

German Measles

Date of last TB Mantoux test if taken Result:

Immunization Verification—PLEASE FILL OUT COMPLETELY:

My child received his/her last Tetanus shot (DTP or Booster) on / (This information is **REQUIRED** in case of medical emergency)

*Month/ Year

☐ I verify that my child is up-to-date on ALL immunizations required for school.
 ☐ My child is Exempt from immunizations due to Medical, Religious, or other reasons.

Parent Signature

Medications—You will be asked to complete a “Medications Being Taken” card on the first day of camp if your child is to take medications during their stay at camp. Medications (both prescription and over-the-counter) will only be accepted and dispensed by the Health Officer if provided in their original container and with current prescription labeling. Please check medication labels and expiration dates prior to your arrival at camp. The following medications, stocked in the Camp Health House, are used to manage illness or injury and dispensed as directed by our medical protocols. Please check the box next to those medications your camper **should not** be given:

___ Acetaminophen (Tylenol)	___ Cough Medicine	___ Night Time Cold Formula	___ Tinactin (Anti-Fungal)
___ Aloe	___ Generic Cough Drops	___ Pepto Bismol Tablets	___ Triple Antibiotic Cream
___ Allergy Medication	___ Ibuprofen	___ Pseudoephedrine (Sinus)	ALL OKAY (initial)
___ Benadryl	___ Kaopectate (Anti-Diarrheal)	___ Sore Throat Drops/Spray	

Are there any camp activities from which this participant should be exempt for health reasons? If so, please list.

Is there any other information which has an impact upon the participant’s ability to fully participate in our program? If so, please list.

FOR STAFF USE ONLY: Information Verification and Health Screening completed by:

Staff Name (print please)
Date