

YMCA Camp Duncan's Woods 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 503.405.9319 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 Duncan's Woods 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.

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

Explain “yes” answers and please note the question number _____

Name of family physician _____ Phone _____

Name of family dentist/orthodontist _____ Phone _____

<p>Which of the following Diseases has the participant had?</p> <p>Measles _____ Mumps _____</p> <p>Chicken pox _____ Hepatitis _____</p> <p>German Measles _____</p> <p>Date of last TB Mantoux test if taken _____ Result: _____</p>	<p>Immunization Verification—PLEASE FILL OUT COMPLETELY:</p> <p>My child received his/her last Tetanus shot (DTP or Booster) on _____ / _____ (This information is REQUIRED in case of medical emergency) <small>*Month/ Year</small></p> <p><input type="checkbox"/> I verify that my child is up-to-date on ALL immunizations required for school. <input type="checkbox"/> My child is Exempt from immunizations due to Medical, Religious, or other reasons.</p> <p>Parent Signature _____</p>
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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 Camp staff 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 at Camp 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)
___	___ Generic Cough Drops	___ Pepto Bismol Tablets	___ Triple Antibiotic Cream
___ Allergy Medication	___ Ibuprofen	___	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 _____