

YMCA Camp Collins Health History Form

Name _____ Age at camp _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Social security number of participant _____ Gender: Male Female Phone _____

Custodial parent/guardian _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Business Phone _____ Cell Phone _____ Pager _____

Second Parent or Guardian or Emergency Contact _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Business Phone _____ Cell Phone _____ Pager _____

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

Home Phone _____ Business Phone _____ Cell Phone _____ Pager _____

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

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

Name of insured _____ Relationship to participant _____

Phone of carrier _____ Social security number of policy holder or insurance ID number _____

Health History

The following information must be filled in by the parent/guardian, or adult camper or staff member. We use this information to provide healthcare staff with background about your child and to educate counseling staff about camper needs. (Continued on reverse side)

Allergies: Please check those which apply to this camper.

- This camper has no known allergies
- This camper has an allergy to the following food(s): _____ This causes anaphylaxis..... Yes No
Describe the reaction if this food is eaten and what is done to manage it:

- This camper is allergic to the following medication(s): _____ This causes anaphylaxis..... Yes No
Describe the reaction and how it has been managed:

- This camper is allergic to the following substance(s): _____ This causes anaphylaxis..... Yes No
Describe the reaction and what is done to manage it (attach additional information if needed):

Diet: Please check those which apply to this camper. We can work with some medically prescribed diets but cannot cater to individual food preferences.

Please call if you have questions regarding your camper's diet while at camp 503-663-5813.

- This camper eats a regular, varied diet and is prepared to eat a wide range of foods.
- This camper is a vegetarian of the following type: Semi-vegetarian (no pork or beef) Pesco (no beef, pork, or chicken)
- This camper is lactose-intolerant. Lacto-ovo (no beef, pork, chicken, seafood or fish) Vegan (no meats, eggs or dairy)

Parent/Guardian Authorization for Health Care:

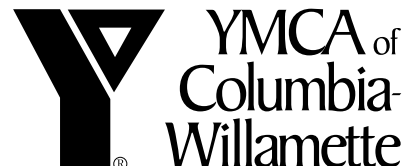
This health history is correct, and the person described has permission to participate in all camp activities except as noted by me and/or a physician. I give permission to the medical personnel selected by YMCA Camp Collins to order X-rays, routine tests, and treatment; to release any records necessary for insurance purposes; and provide or arrange necessary related transportation for myself/my child. 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 camper/staff _____ **Date** _____

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

Signature of camper _____

Date _____



Please Complete Both Sides

Chronic Concerns

- This camper has no chronic health concerns and is capable of full participation in this program
- This camper has the following chronic health concern(s):
 - Asthma
 - 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:

General Questions (Please explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="radio"/>	<input type="radio"/>	10. Ever had back problems?	<input type="radio"/>	<input type="radio"/>
2. Ever been hospitalized?	<input type="radio"/>	<input type="radio"/>	11. Ever had problems with joints (e.g. knees, ankles)?	<input type="radio"/>	<input type="radio"/>
3. Ever had a head injury?	<input type="radio"/>	<input type="radio"/>	12. Have an orthodontic appliance being brought to camp?	<input type="radio"/>	<input type="radio"/>
4. Ever been knocked unconscious?	<input type="radio"/>	<input type="radio"/>	13. Have any skin problems (e.g. itching, rash acne)?	<input type="radio"/>	<input type="radio"/>
5. Wear glasses, contacts or protective eye wear?	<input type="radio"/>	<input type="radio"/>	14. Had mononucleosis in the past 12 months?	<input type="radio"/>	<input type="radio"/>
6. Ever passed out during or after exercise?	<input type="radio"/>	<input type="radio"/>	15. Had problems with diarrhea/constipation?	<input type="radio"/>	<input type="radio"/>
7. Ever had chest pains during or after exercise?	<input type="radio"/>	<input type="radio"/>	16. If female, have an abnormal menstrual history?	<input type="radio"/>	<input type="radio"/>
8. Ever have high blood pressure?	<input type="radio"/>	<input type="radio"/>	17. Have an eating disorder?	<input type="radio"/>	<input type="radio"/>
9. Ever been diagnosed with a heart murmur?	<input type="radio"/>	<input type="radio"/>	18. Ever had emotional difficulties for which professional help was sought?	<input type="radio"/>	<input type="radio"/>

Please explain any "yes" answers, noting the number of the questions.

Name of Family Physician _____ Phone _____

Name of Family Dentist/Orthodontist _____ Phone _____

Which of the following has the participant had?

- Measles
- Chicken pox
- German measles
- Mumps
- Hepatitis

_____ Date of last TB Mantoux test Result _____

Please give dates of last immunization for:

<i>Date</i>	<i>Vaccine</i>	<i>Date</i>	<i>Vaccine</i>
_____	DTP (Diphtheria, Tetanus, Pertussis)	_____	Hepatitis B
_____	Td (Tetanus booster)	_____	Vericella (Chicken Pox)
_____	MMR (Mumps, Measles, Rubella)	_____	Haemophilus influenza B
_____	IPV/OPV (Polio)		

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 (including over-the-counter or nonprescription drugs) during their stay at camp. Please bring the medication in the original container to camp. **The following medications, stocked in the Camp Health House are used to managed illness or injury and dispensed as directed by our medical protocols. Cross out those which your camper should not be given:**

- | | | | |
|-------------------------|----------------------------|-------------------------|------------------------|
| Acetaminophen (Tylenol) | Diphenhydramine (Benadryl) | Sore throat drops/spray | Pseudoephedrine |
| Allergy Medication | Cough Medicine | Tinactin | NightTime Cold Formula |
| Calamine Lotion | Ibuprofen | Generic cough drops | Aloe |
| Bismuth chew tablets | Kaopectate | Triple antibiotic cream | |

What have we forgotten to ask? Please provide additional information about your child's health which may have been neglected on this form.

We are particularly interested in information which has impact upon you child's ability to fully participate in our program.
