

YMCA CAMP REED

2012 HEALTH HISTORY FORM / PARENT PERMISSION FORM

DUE JUNE 1, 2012

The information on this form is not part of the jc or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided in writing to the camp nurse upon participants arrival in camp. Provide complete information so that the camp can be aware of your needs. DO NOT FAX THE FORM.

PLEASE CIRCLE PROGRAM

TRADITIONAL / MINI / CIT / JC / STAFF

Week(s) at Camp -- Check every week attending

- | | |
|--|--|
| <input type="checkbox"/> Week 1: 6/17-6/23 | <input type="checkbox"/> Week 5: 7/15-7/21 |
| <input type="checkbox"/> Week 2: 6/24-6/30 | <input type="checkbox"/> Week 6: 7/22-7/28 |
| <input type="checkbox"/> Week 3: 7/1-7/7 | <input type="checkbox"/> Week 7: 7/29-8/4 |
| <input type="checkbox"/> Week 4: 7/8-7/14 | <input type="checkbox"/> Week 8: 8/5-8/11 |

Participant Name: _____

Male Female Date of Birth: _____ Age as of 06/01/12: _____ Grade Entering Fall 2012 _____

Parent / Guardian Name: _____ Cell Phone: _____ Phone #2: _____

Parent / Guardian Name: _____ Cell Phone: _____ Phone #2: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact #1: _____ Relationship: _____ Cell Phone: _____ Phone #2: _____

Emergency Contact #2: _____ Relationship: _____ Cell Phone: _____ Phone #2: _____

Parent/Guardian will be contacted first in an emergency. If unavailable, emergency contacts will be called.

MEDICAL INFORMATION

Name of family physician: _____ Phone: _____

Name of family dentist / orthodontist _____ Phone: _____

PAYMENT

(Required at clinic or hospital for any medical treatment)

INFORMATION

Please indicate method of payment:

Self pay Please identify name & address of person responsible for payment _____

Insurance
Name of insured _____ Relationship to participant _____
Carrier or plan name _____ Group # _____ Insurance ID # _____

Medicaid Please attach copy of current coupon.

*IMPORTANT - THIS BOX MUST BE COMPLETED FOR ATTENDANCE

I understand and certify that participation in YMCA Camp Reed and its activities is completely voluntary and I have had the opportunity to familiarize myself with the camp program and activities in which my child/participant will be engaging. I recognize that certain hazards and dangers are inherent in Camp Reed programs and particularly, but not limited to, the activities of archery, arts and crafts, BB marksmanship, biking, boating, day and night hiking, horse back riding, pottery, high and low ropes courses, rock climbing wall, rappelling, riflery, sports, swimming, waterfront games, and out of camp overnight trips. 13-14 year old campers may take a 20-mile overnight bike trip which travels on public roads. The CIT bike trip is 300 miles also on public roads. All activities are more fully described in the YMCA Camp Reed Parent Handbook or applicable CIT information, which I agree to read. I acknowledge that although Camp Reed has taken safety measures to minimize the risk of injury to camp participants, Camp Reed cannot insure or guarantee that the participants, equipment, premises, and/or activities will be free of all hazards, accidents, and/or injuries. I understand that it is my responsibility to provide insurance for my child. I further recognize the importance of knowing and abiding by Camp Reed's rules, regulations, and procedures for the safety of camp participants.

This health history form is correct and complete as far as I know and it is my opinion that the applicant is physically, emotionally and mentally able to engage in all camp activities, except as specifically noted on the reverse of this form. I hereby give permission to the camp to provide routine health care, dispense prescribed medications, administer over the counter medications and seek emergency medical or dental treatment including ordering x-rays or tests deemed necessary by the health care providers. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary transportation. In the event I cannot be reached in an emergency, I hereby give permission to the medical provider selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

I agree to allow the YMCA of the Inland Northwest to use my child's/participant image for publicity and marketing.

If there are any changes to this form, I agree to provide the Camp nurse with the updated and accurate information IN WRITING at the time of check in.

Signature of participant or parent/guardian if under 18: _____ Date: _____

Printed Name: _____

MEDICAL INFORMATION

PARTICIPANT'S NAME: _____

IMMUNIZATION HISTORY: MANDATORY - INITIAL IF PARTICIPANT IS CURRENT WITH THE FOLLOWING

___ Polio ___ Mumps ___ Rubella ___ Diphtheria ___ Pertussis ___ Measles Date of last Tetanus Immunization: _____

Asthma ___ YES ___ NO Cardiac Defect/Disease ___ YES ___ NO
ADD/ADHD ___ YES ___ NO Bedwetting ___ YES ___ NO
Seizures ___ YES ___ NO Recent Hospitalization ___ *YES ___ NO
Other Diseases/Conditions ___ *YES ___ NO *Describe _____
*Describe _____

Please Note: If your camper has special health needs (including but not limited to: insulin dependence, cardiac illness, severe asthma, seizure disorder, autism, or severe allergies), you must contact the camp director for advance clearance. On a case by case basis, we consult with parent/guardian and our camp nurse to determine if accommodation and appropriate care is available.

1. Describe any other significant PAST medical treatment or history. _____

2. Describe any CURRENT physical, mental development, or psychological conditions requiring medication, treatment, special restrictions or considerations while at camp. _____

3. Is the participant presently under the care of a physician for any conditions? ___ YES ___ NO
Name & Phone # of Treating Physician: _____
Explain: _____

4. Describe any camp activities from which the participant should be exempted for health or developmental reasons. _____

5. Any Dietary Restrictions? _____

*Camp Reed is not staffed to accomodate special dietary requests, unless related to allergies or medical condition. If so, prior arrangements must be made.

PRESCRIPTION & OVER THE COUNTER MEDICATIONS

- 1) DO NOT SEND OVER THE COUNTER MEDICATIONS TO CAMP (unless PRESCRIBED BY PHYSICIAN in original container)
2) Bring ONLY enough medications for the participants stay at camp - Sunday through Friday (pharmacy will package for you)
*The nurse does not see participants Saturday morning. See parent handbook for more information.
3) Medications will be administered ONLY from prescription bottles identifying prescribing physician, name of medication, dosage and frequency.
4) Utilize medication card to list current medications.

[] Participant will need to take medication while at camp.
*Allow time at check-in to fill out medication card & turn in medication with nurse.

[] Participant does not take medication.

CAMP WILL PROVIDE THE FOLLOWING NON-PRESCRIPTION MEDICATIONS

Non-prescription medications: I authorize the following medications to be administered as needed:

Acetaminophen ___ YES ___ NO Ibuprofen ___ YES ___ NO
Cough Syrup ___ YES ___ NO Benadryl ___ YES ___ NO
Antacid ___ YES ___ NO Sudafed ___ YES ___ NO
Loratadine (claritin) ___ YES ___ NO

ALLERGIES: LIST ALL KNOWN: medications, food, enviornmental

Allergy: Circle all that apply: Describe severity, typical reaction, preferred response:
airborne ingested contact
airborne ingested contact
airborne ingested contact
airborne ingested contact
airborne ingested contact