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We build strong kids,
strong families,
strong communities.

YMCA Camp Roger

YMCA of Greater Salt Lake
Camp Roger
Camper Health History Form

Name____Birthdate___________Age_______
Last First MI

Home Address____
Street City State Zip

Custodial Parent or Guardian____

Home Phone__________________________________ Cell/Work Phone__________________________

Address if different from camper's____
Street City State Zip

Second Custodial Parent or Guardian____

Home Phone__________________________________ Cell/Work Phone__________________________

Address if different than camper's____
Street City State Zip

Health History

Gender ☐ M ☐ F Height________ Weight________ Eye Color________ Hair Color______

List all known allergies____

____

List all restrictions (dietary, activity or other):____

____

List and explain all medical conditions or care the camper has or has had in the past 2 years___________

____

____

Special instructions for routine care (restroom use, bathing, eating, sleeping), if any_________________

____

____

Medications
Camper is currently taking medications. ☐ Yes ☐ No
If yes, please list the medication, dosage, times for dispensing. All medications must be labeled and given to camp nurse upon arriving at camp check-in.

Medication 1_________________________________Dosage_________________Time______________

Medication 2__________________________________Dosage_________________Time_____________

Medication 3__________________________________Dosage_________________Time_____________

Please complete the information on the back of this form

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YMCA CAMP ROGER

Camper's Name____
Last First MI

Immunization History: Please list the most recent dates for the following vaccines/tests.

DTP ____________________

TD (Tetanus/Diptheria)____________________

Tetanus____________________

Polio____________________

MMR____________________
(or Measles, Mumps and/or Rubella)

Haemophilus influenza B____________________

Hepatitis B____________________

Varicella (Chicken Pox)____________________

TB Mantoux Test_____ ☐ Positive ☐ Negative

Family Physician____Phone____________________

Family Dentist/Othodontist________________________________Phone____________________

Insurance Information: Is the camper covered by medical/health care insurance? ☐ Yes ☐ No

If yes, Name of Carrier________________________________ Policy Number________________

Name of Primary Insured______________________________ Social Security #______________

Health Care Recommendation by Licensed Medical Personnel

I have examined this individual on ____________________(date). In my opinion, this individual

☐ is ☐ is not able to participate in an active camp program.

Recommendations or Restrictions____

____

Signature of Licensed Medical Personnel____

Printed Name____Date____________________

Title________________________ Phone Number________________________________

Parent/Guardian Authorization: This health history is correct and complete to my best knowledge. The person described has permission to engage in all camp activities except as noted. I give permission to the camp to provide routine health care, including over the counter medications, administer prescribed medications as directed in this document, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary medical related transportation. In the event of an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization for the person named above. I understand that medical costs incurred are my responsibility, to be covered by my own medical insurance or resources. This complete form may be photocopied for trips out of camp.

Signature of Parent/Guardian____

Printed Name____Date____________________