



**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 _____

Address if different from camper's _____
Street City State Zip

Second Custodial Parent or Guardian _____

Home Phone _____ Cell _____ Work _____

Address if different than camper's _____
Street City State Zip

Emergency Contact if Parent or Guardian cannot be reached _____
Name Relationship

Home Phone _____ Cell _____ Work _____

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

Camper's Name _____
Last First MI

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

DTP _____
 TD (Tetanus/Diphtheria) _____
 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 _____