

Camper Health History and Examination Form
Important Information
Please Read

The health and well-being of your child is of primary importance to the staff of YMCA Camp Roger. The most current health information and a physician's examination within 24 months of your child's attendance at camp is the foundation for us to accomplish this task. Please take a few moments to read this information before filling out the health history and examination form. If you have any questions please don't hesitate to call the Camp Roger office at (801) 466-6299 or email us at camproger@ymcasaltlake.org

1. Page 1 is to be filled out by the parent of the camper. Although, we may have this on file from a camper who has attended camp last year, we must have a new, updated one for each year that a camper attends summer camp.
2. Page 2 to be filled out by the camper's physician, we cannot permit a child to attend Camp Roger without a doctors approval.
3. If your camper has had a physical within 24 months of his or her camp session, you may attach a copy of the physical to the health history form.
4. If your camper takes any prescription medication they will be collected by our health supervisor during check-in and administered at the proper times, as directed on the prescription.
5. All prescription medication must be in the container issued by the pharmacy and have the camper's name and dosage on the label or written consent and instructions by a physician. This is necessary if the camp health supervisor is to administer any medication.
6. Please do not send medication for your camper that has been taken out of its original container and packed into individual bags/containers.
7. **Each camper will be checked for head lice during check-in. If any evidence of lice or nits are present, the camper's parent(s) will need to have this treated and may reschedule him/her for another available camp session.**

We look forward to working with your child this summer with all the benefits of a fun, safe and healthy experience.

**YMCA Camp Roger
Camper Health History Form**

This page to be filled out by parents/guardian of minors or by adult staff members for themselves

CAMPER: Last Name _____ First Name _____ MI _____
 Birthdate ____/____/____ Sex ____ Age ____ Height _____ Weight _____ Eye Color _____ Hair Color _____
 Home Address _____ City _____ State _____ Zip _____
 Parent/Guardian: Name _____ Home _____ Cell _____ Work _____
 Parent/Guardian: Name _____ Home _____ Cell _____ Work _____

If not available in an emergency, please notify:
 Name _____ Relationship _____
 Home Phone # (____)-____-____ Cell Phone # (____)-____-____ Work Phone # (____)-____-____

General Health History:
 Check "Yes" or "No" for each statement.
 Explain "Yes" answers below

1. Frequent Ear Infections..... Yes No
2. Heart Defect/Disease..... Yes No
3. Convulsions/ Seizures Yes No
4. Diabetes..... Yes No
5. Bleeding /Clotting Disorders. Yes No
6. Hypertension..... Yes No
7. Mononucleosis (Mono)..... Yes No
8. Psychiatric Treatment..... Yes No
9. Treated for ADD or AD/HD.. Yes No
10. Back/joint problems..... Yes No
11. Chronic or recurring illness... Yes No
12. History of bedwetting..... Yes No
13. History of headaches..... Yes No

Please explain 'yes' answers below, noting the number of the questions. The camp may contact you for additional information.

List all known allergies _____
 Operations or serious injuries (Dates) _____
 Activities encouraged or restrictions by physician _____
 Dietary Modifications _____
 Special instructions for routine care, if any _____
 Other diseases or details of above _____

FOR FEMALE:
 Has this person menstruated? _____ If not, has she been told about it yet? _____
 If so, is her menstrual history normal? ____ Special considerations _____

Medications must be in original container, include instructions, and tuned into health center upon arriving at camp.

Medication 1 _____	Dosage _____	Time _____
Medication 2 _____	Dosage _____	Time _____
Medication 3 _____	Dosage _____	Time _____

Important – This Section Must be Completed for Attendance

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.

Non-Prescription Medications: I authorize the following medications (or generic equivalent) to be administered as needed:

Tylenol <input type="checkbox"/> Yes <input type="checkbox"/> No	Sucrets <input type="checkbox"/> Yes <input type="checkbox"/> No	Pepto Bismol <input type="checkbox"/> Yes <input type="checkbox"/> No	Benadryl <input type="checkbox"/> Yes <input type="checkbox"/> No
Chloraseptic <input type="checkbox"/> Yes <input type="checkbox"/> No	Cough Drops <input type="checkbox"/> Yes <input type="checkbox"/> No	Ibuprofen <input type="checkbox"/> Yes <input type="checkbox"/> No	Cough Syrup <input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of parent or guardian or adult staff _____
 I also understand and agree to abide with the restrictions placed on my camp activities.
 Signature of minor _____

Insurance Information: Is camper covered by medical/hospital insurance? Yes No
Include a copy of your insurance card if appropriate; copy both sides of the card so information is reliable

Carrier _____ Policy or Group # _____
 Subscriber _____ Insurance Company Phone # (____)-____-____
 Name of dentist/orthodontist _____ Phone # (____)-____-____
 Name of family physician _____ Phone # (____)-____-____

CAMPER: Last Name _____ First Name _____ MI _____

Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable, please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
★Diphtheria, Tetanus, Pertussis (DTaP) or (TdaP)						
★Tetanus booster (dT) or (TdaP)						
★Mumps, Measles, Rubella (MMR)						
★Polio (IPV)						
Pneumococcal (PCV)						
Haemophilus influenza b (HIB)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)	Had chicken pox Date:					
Meningococcal meningitis (MCV4)						

If your camper has not been fully immunized, please sign the following statement:
I understand and accept the risks to my child from not being fully immunized.

Signature of Parent/Guardian: _____

Health Care Recommendation by Licensed Medical Personnel

I have examined this individual within the past two years. Date Examined _____

The applicant is under the care of a physician for the following condition(s) _____

Current treatment (including current medications) _____

Explanation of any reported loss of consciousness, convulsions, or concussion _____

Does applicant have epilepsy? Yes No Does applicant have diabetes? Yes No

Recommendations and Restrictions while at camp: _____

Any treatment to be continued at camp _____

Any medication to be administered at camp (specific dosages) _____

Any allergies (food, drugs, plants, insects, etc.) _____

Additional health information _____

I have reviewed the Camper Health History Form and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion, the camper is physically and emotionally fit to participate in an active camp program (excepts as noted above.)

Licensed Physician's Signature _____

Address _____ Phone _____
Street City State Zip Area/Number

Date of Form Completion _____ *By _____

*Initial if completed by nurse or physician's assistant