

**Adult Health History and Examination Form**  
**Important Information**  
**Please Read**

The health and well-being of the staff of YMCA Camp Roger is a primary importance to us. The most current health information and a physician's examination within 24 months of your employment 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](mailto:camproger@ymcasaltlake.org)

1. Page 1 is to be filled out by the staff member or parent of staff under the age of 18. Although, we may have this on file from staff who has worked at camp last year, we must have a new, updated one for each year that an individual works at summer camp.
2. Page 2 to be filled out by the employee's physician, we cannot employ an individual at Camp Roger without a doctors approval.
3. If you have had a physical within 24 months of your employment, you may attach a copy of the physical to the health history form.
4. If you take any prescription medication they will be collected by our health supervisor during staff training 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 employees 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 bring medication that has been taken out of its original container and packed into individual bags/containers.
7. **Each employee will be checked for head lice periodically throughout the summer. If any evidence of lice or nits are present, the employee will need to have this treated and may be asked to vacate camp until resolved.**

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

**YMCA Camp Roger  
Employee 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 \_\_\_\_\_  
 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**

**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 may be 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 individual 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 being fully immunized.

Signature of Parent/Guardian or adult staff: \_\_\_\_\_

**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 Health History Form and have discussed the camp program with the individual. It is my opinion, the individual 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