

**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*

Camper's Name \_\_\_\_\_  
Last First MI

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

DTP \_\_\_\_\_

Haemophilus influenza B \_\_\_\_\_

TD (Tetanus/Diphtheria) \_\_\_\_\_

Hepatitis B \_\_\_\_\_

Tetanus \_\_\_\_\_

Varicella (Chicken Pox) \_\_\_\_\_

Polio \_\_\_\_\_

TB Mantoux Test \_\_\_\_\_  Positive  Negative

MMR \_\_\_\_\_

(or Measles, Mumps and/or Rubella)

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 \_\_\_\_\_