



Please circle session(s) attending: Camp 1 2 3 4

Camp Discovery circle week(s) attending: 1 2 3 4 5 6 7 8

Camp Health Form Summer 2013

This side to be completed by parent/guardian.

Important- By state regulation your child may not attend camp until this form is fully completed and signed on both sides. Please return to camp by May 1st. Please do not send in until both sides are completed.

Please print or type.

Child's Name _____ Birth Date _____ M ___ F ___
Last First Middle

Address _____ City _____ State _____ Zip _____

Mother/ Guardian _____ Home # _____ Cell # _____

Father/ Guardian _____ Home # _____ Cell # _____

Mother's Employer _____ Work # _____

Father's Employer _____ Work # _____

Child lives with _____

If parent cannot be reached, give name and relationship of person to be called in case of emergency.

_____ Home # _____ Work # _____ Cell # _____

Medication, Allergies, Handicaps

Please list all medications that your child is taking. If your child will be taking any medications (prescription or over-the-counter) during camp, you must attach a doctor's medication authorization form.

Is there any medication that your child takes during the school year that they will not be taking during the camp season _____

Does your child have an allergic reaction to ___ Bees ___ Medication ___ Food ___ Other _____

What symptoms may occur? _____

Does your child carry an Epi-Pen? ___ Yes ___ No If yes, one must be provided to camp.

Please use this space provided to provide us with any additional information of the child's behavior, emotional, physical and mental health that the camp should be aware of _____

Insurance Information

Is the participant covered by family medical / hospital insurance? ___ Yes ___ No

Carrier or plan name _____ Group # _____ ID # _____

Name of insured _____ Relationship to participant _____

Permission to Provide Necessary Treatment or Emergency Care:

I hereby give permission to the Lakewood-Trumbull YMCA medical personnel or the camp director to order X-Rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or staff X _____ Date _____

Please print your name _____

Mail completed signed form to:

LAKWOOD-TRUMBULL YMCA

YMCA CAMP TEPEE

P.O. Box 89, Monroe CT 06468

P 203 261 2566 F 203 261 3146



Camp Health Form

This side to be completed by a Physician

Name of camper _____ Date of Birth _____

Date of last physical (must be within 2 years) _____

Please use a separate form for each camper. You may attach a print out from physician or school health form. This examination is for determining fitness and endurance in potentially strenuous activities. All of the information on this form must be completed.

General Information

Height _____ Weight _____ Blood Pressure _____ Heart Rate _____

Immunization History: Please provide confirmation and dates of following immunizations:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Polio		
Tetanus			PCV7		

Medical Conditions

Has the child ever had, or does he/she now suffer from:

___ Allergy requiring EPI-Pen ___ Asthma (inhaler Y/N) ___ Headaches ___ Seizures

___ Diabetes (___ insulin pump ___ coverage at camp) ___ High/Low Blood Pressure

___ Other reason for medication, please explain.) _____

___ Recent or Recovering Fractures or other injuries (explain) _____

___ Genetic Disorder (explain) _____

___ Any physical restrictions: swimming, diving, hiking, climbing, running or other.

Please explain _____

Other health history: _____

Recommendations

Special Diet: _____ Medication: _____ Other: _____

• Medication Authorization Form must be sent by physician before nurse can give any medications, including over-the-counter. Parent must provide the medication with the form and is responsible to pick them up at the end of the session.

Physical Authorization

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in an active camp program.

Print name of medical care provider: _____

Print address of medical care provider: _____

Signature of physician, APRN or PA _____ Date _____

Phone _____ Address _____