Please Circle Week/Session(s)
Attending: Camp 1 2 3 4 5 6 7 8 9

Camp Health Form
Summer 2012

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

Does your child have ____ADD/ ADHD ___Autism ___Down Syndrome ___Asthma ___Diabetes
Please list 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._____
Any Physical Handicaps _____
Does your child have an allergic reaction to
____Bees _____Medication ____Food ___Other (Describe) _____
What symptoms may occur? _____
Does your child carry an Epi-Pen? ____Yes ____No If yes, one must be provided to camp.

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 herby give permission to the Valley 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:
Valley YMCA, 12 State Street
Ansonia, CT 06401

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_____

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 _____