



YMCA CAMP WINONA

Health History Form

This form must be filled out in its entirety, signed by the camper's parent/guardian, and returned with physical and waivers to the camp office prior to your camper's session (two weeks prior is preferred).
Email the completed form to **campwinona@vfymca.org**

Camper's Name _____ Gender Male Female
Mailing Address _____ Birthday ____/____/____ Age ____
_____ Upcoming Grade _____



CONTACT INFORMATION IN CASE OF ILLNESS OR INJURY

Camper Lives With _____ Relationship To Camper _____
First Guardian's Name & Email _____
Primary Guardian's Phone # _____ Alternate Phone # _____
Second Guardian's Name & Email _____
Second Guardian's Phone # _____ Alternate Phone # _____
Emergency Contact Name _____ Relation to Camper _____
Emergency Contact Phone # _____ Alternate Phone # _____



CAMPER MEDICAL INFORMATION

Name of Family Physician _____ Phone # _____
Name of Family Dentist _____ Phone # _____
Name of Family Orthodontist _____ Phone # _____



MEDICAL INSURANCE INFORMATION

Camper is covered by family medical/hospital insurance Yes No

If yes, please include a copy of your insurance card (both sides)

Insurance Company _____ Phone # _____
Subscriber _____ Policy # _____



GENERAL HEALTH HISTORY

Please check if any of the below apply

- Recent injury, illness, or infectious disease
- Ever been hospitalized
- Chronic or recurring illness/condition
- Ever had surgery
- Ever had seizures
- Skin conditions
- Diabetes
- Asthma/Wheezing/Shortness of Breath
- Headaches
- Fainting/Dizziness
- Passed out/chest pain during exercise
- Back/joint problems
- Regular diarrhea/constipation
- Frequent ear infections
- Heart defect/disease
- Blood disorder (hepatitis, HIV, clotting, etc)
- Nosebleeds
- Hypertension
- Mononucleosis
- Chicken Pox
- Measles/German Measles
- Mumps
- Sleepwalking or night terrors
- History of bedwetting
- Wakes in night to use restroom
- History of being afraid of the dark
- History of noise while sleeping (snores, talks, etc)
- Menstruation problems
- Glasses/Contact lenses
- Braces, retainers, or other dental items
- Ever had professional help for behavioral or emotional difficulties
- Mental health hospitalization
- Eating disorders
- Depression
- Attention Deficit Hyperactivity Disorder
- Anxiety
- Tourette's Syndrome
- Autism Spectrum Disorder
- Behavior Disorder
- Obsessive Compulsive Disorder
- Schizophrenia
- Bipolar Disorder
- Pervasive Development Disorder
- Oppositional Defiant Disorder
- Learning Disability
- Traveled outside the country in the past 12 months_____
- Have any restrictions to activities (what cannot be done/adaptations/limitations necessary)
- Significant life event that continues to affect Camper's life (abuse, death, family changes, etc)
- Additional concerns Camp should be aware of (behavior, physical, emotional health, etc)

Please explain all checked items or anything we have forgotten ask _____



IMMUNIZATION HISTORY

Please initial one or the other

- _____ I hereby verify that my child is current on all immunizations required for school. Please include a current copy of immunizations OR fill out the information below.
- _____ If your camper has not been full immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Parent/Guardian

Date

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Booster Month/Year
Diphtheria, tetanus, pertussis (DtaP or TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenza Type B (HIB)						
Pneumoccal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)						
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) Test	Date: _____	Negative <input type="checkbox"/>	Positive <input type="checkbox"/>			



ALLERGIES Please check if any of the below apply. If checked, please state if the allergy is mild, moderate, or severe AND if the allergy is contact or airborne.

- Animal _____
- Insect Stings
- Medicine _____
- Penicillin
- Environmental (Pollen, trees, mold, etc)
- Peanut/Tree Nut
- Food _____
- Other _____

Severity of reaction and action plan for your camper _____



DIET & NUTRITION Please check if any of the below apply.

- Vegetarian
- Vegan
- Lactose Intolerant
- Gluten Intolerant
- No Red Meat
- Other _____



MEDICATIONS Please list ALL medications (including over-the-counter and non-prescription) that are taken routinely by the camper. Please bring enough medication to last for the whole week. ALL medication must be in its original packaging that identifies prescribing physician (if prescribed), the name of the medication, dosage, and frequency.

- This camper does not take any medication
- This camper takes routine medication (including vitamins) as follows:

Medication	Dosage	Times Taken	Reasons for taking
		_____ Breakfast _____ Bedtime _____ Lunch _____ Other _____ Dinner _____	
		_____ Breakfast _____ Bedtime _____ Lunch _____ Other _____ Dinner _____	
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		_____ Breakfast _____ Bedtime _____ Lunch _____ Other _____ Dinner _____	
		_____ Breakfast _____ Bedtime _____ Lunch _____ Other _____ Dinner _____	
		_____ Breakfast _____ Bedtime _____ Lunch _____ Other _____ Dinner _____	
		_____ Breakfast _____ Bedtime _____ Lunch _____ Other _____ Dinner _____	

The following medications may stocked in our Health Center and are dispensed by our Health Administrators on an as needed basis.

Please cross out any medications which your camper SHOULD NOT be given:

- Acetaminophen (Tylenol)
- Aloe Vera lotion or spray
- Antibiotic cream
- Antihistamine/allergy medicine
- Bismuth subsalicylate for diarrhea (Pepto-Bismol, Kaopectate)
- Calamine lotion
- Cough drops
- Dextromethorphan cough syrup (Robitussen DM)
- Diphenhydramine antihistamine/allergy medicine (Bendryl)
- Epsom Salt
- Guaifenesin cough syrup (Robitussen)
- Hydrocortisone Cream
- Hydrogen Peroxide
- Ibuprofen (Advil, Motrin)
- Laxatives for constipation
- Phenylephrine decongestant (Sudafed PE)
- Pseudoephedrine decongestant (Sudafed)
- Rubbing Alcohol
- Sore throat spray
- Sterile eye drops
- Tums
- Other _____



AUTHORIZED PICK UP LIST *(in addition to Parents/Guardians on 1st page)*

Name _____ Relationship: _____

Phone # _____ Alternate Phone # _____

Name _____ Relationship: _____

Phone # _____ Alternate Phone # _____

Name _____ Relationship: _____

Phone # _____ Alternate Phone # _____

Name _____ Relationship: _____

Phone # _____ Alternate Phone # _____

Name _____ Relationship: _____

Phone # _____ Alternate Phone # _____



PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE

This health history is correct and accurately reflects the health status of (camper to whom it pertains) _____. S/he has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Primary Guardian Signature _____

Date _____

If for religious or other reasons, you cannot sign this, please contact camp for a legal waiver which must be signed for attendance.

FOR CAMP USE ONLY

Any signs/symptoms of illness/injury upon arrival? YES NO

Does the camper have medications? YES NO

Does the camper have allergies? YES NO

Head checked and cleared? YES NO