YMCA Camp Winona

Health History Form

This form must be filled out completely, signed by the camper's parent/guardian, and returned with requested documentation to the camp office TWO weeks prior to your camper's session.
Email the completed form to campwinona@vfymca.org

Camper's Name _____ Birthday _____/_____/_____ Age____

Home Address _____ Grade in Fall 2020 _____

_____ Gender Male Female

CONTACT INFORMATION IN CASE OF ILLNESS OR INJURY

Camper Lives With _____ Relationship To Camper _____

Home Address (if different from above)_____

First Guardian's Name & Email_____

First 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 Number _____

Subscriber_____ Policy Number _____

☑ GENERAL HEALTH HISTORY

Please check if any of the below apply.

- ☐ Recent injury, illness, or infectious
- ☐ 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)
- ☐ 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 to ask_____

_____

_____

_____

IMMUNIZATION HISTORY:

☐ _____ I hereby verify that my child is current on all immunizations required for school.
You must include a current copy of immunization records from your health care professional OR fill out the information below.

☐ _____ If your camper has not been fully 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
Diptheria, 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 ☐	Positive ☐			

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_____ ☐ Penicillin ☐ Peanut/Tree Nut
☐ Insect Stings ☐ Environmental (Pollen, trees, mold, etc) ☐ Food _____
☐ Medicine_____ ☐ Other _____

Severity of reaction and action plan for your camper _____
_____

DIET & NUTRITION

Please check if any of the below apply.

☐ Vegetarian ☐ Lactose Intolerant ☐ Other _____
☐ Vegan ☐ Gluten Intolerant _____

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

The following medications may be 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 <u>SHOULD NOT</u> 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 (Benadryl)
- Epsom Salt
- Guaifenesin cough syrup (Robitussen)
- Hydrocortisone Cream
- Hydrogen Peroxide
- Ibuprofen (Advil, Motrin)
- Lice shampoo or cream (Nix or Eliminate)
- 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 test, 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 records from providers who treat my child and these providers may talk with the program's staff about my child's health status.

_____

Parent/Guardian Signature Date

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

FOR CAMP USE ONLY

Is all the information current? YES ☐ NO ☐

Does the camper have medications? YES ☐ NO ☐

Does the camper have allergies? YES ☐ NO ☐

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

Head checked and cleared? YES ☐ NO ☐