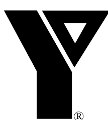
Camper Name: ____ **SESSION ATTENDING:**____________

Last First Middle



Saginaw YMCA Camp Timbers

Health History and Examination Form

Birth date: ____________________ Age at Camp: __________ Gender: Male Female

Custodial Parent/Guardian: ____ Phone: ____________________

Home Address: ____

Street Address City State Zip

Work Phone:_____________________________ Cell Phone or Pager:____________________________

Second Parent / Guardian / Emergency Contact (Please circle one):____________________________________

Home Address: ____ Phone: ____________________

Street Address City State Zip

Work Phone: ____________________________ Cell Phone or Pager: ___________________________

If not available in an emergency, notify: __________________________________ Relationship: _______________

Home Phone: _______________ Work Phone: __________________ Cell Phone or Pager: ____________________

Insurance Information

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

If yes, indicate carrier or plan name: _____________________________________ Group #: ____________________

Carrier Address: ____

Name of Insured: ___________________________________ Relationship to Camper: _________________________

Insurance ID Number: ____

Photocopy of front and back of health insurance card must be attached to this form.

Medications

List all over-the-counter, non-prescription and prescription drugs taken regularly by the camper. Bring enough medication to last the entire time at camp. Keep all medication in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. ***On the day of Camp check-in, Camper's will not be administered their first dose of medication until after 4:00 p.m***.

*****_**Put all medications into a Ziploc bag labeled with the Camper's name and take to Camp check-in**_.*****

The Camper takes NO medications on a routine basis.

This Camper takes medications as follows:

Med #1: ____________________ Dosage:__________ Specific times taken each day:__________

Reason for taking: ____

Med #2: ____________________ Dosage:__________ Specific times taken each day:__________

Reason for taking: ____

Med #3: ____________________ Dosage:__________ Specific times taken each day:__________

Reason for taking: ____

Has the Camper had any recent illness, injury or infectious disease? Yes No

If yes, please explain: ____

Important – The information below must be completed for attendance*

I hereby give permission to the medical personnel selected by the Camp Director to provide routine health care; to administer medications; to order x-rays; routine tests; treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physicians selected by the Camp Director to secure and administer treatment, including hospitalization, for the person named above. YMCA Camp Timbers will make every attempt to notify you before making a doctor's appointment or an emergency room visit for your child while they are in our care. All minor medical needs will be cared for by the on-site Health Director without notification of parents.

Parent/Guardian Signature: ____ Date: ______________________

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

Health History (Check if applicable. Include date of most recent occurrence.)

_____ Chicken Pox	_____ Ear Infections	_____ Migraines	_____ Mononucleosis
_____ Measles	_____ Rheumatic Fever	_____ Nosebleeds	_____ Surgeries
_____ Convulsions	_____ German Measles	_____ Braces	_____ Dizziness
_____ Mumps	_____ Diabetes	_____ Heart Murmur	_____ Seizures
_____ Asthma	_____ Behavior	_____ Contact Lenses	_____ Eating Disorders

Other Health concerns or details of any of the above: ____

____

Immunization History (Please list dates as accurately as possible.)

_____ DPT Series	_____ Booster	_____ Tetanus Booster	_____ Hepatitis B
_____ Polio OPV (Sabin)	_____ Booster	_____ Tuberculin Test	_____ MMR

_____ Other (Please list) ____

Health Care Examination/Recommendations by Licensed Medical Personnel

The Health Care Examination section must be completed by a licensed physician before attending Camp. If the Camper has had a general examination for any other reason within the past 12 months, a copy of that health record can be attached.

Camper Name: ______________________________ I examined this individual on ____________________ (date).

BP ________ Weight ________ Height ________

In my opinion, the above applicant is is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions: ______________________________

____

____

Recommendations and Restrictions at Camp

Medically-prescribed meal plan or dietary restrictions: ______________________________________

Medication Allergies — Describe reaction and management/treatment

______________________________ ____

______________________________ ____

Food Allergies/Dietary Restrictions — Describe reaction and management/treatment

______________________________ ____

______________________________ ____

Other Allergies — Describe reaction and management/treatment

______________________________ ____

______________________________ ____

Restrictions/Limitation of Camp activities? (e.g. what cannot be done, what adaptations are necessary, etc.)

____

____

I have examined the person described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted.

Physician Signature: ____ Date: ______________________

All Camper forms can be used for 2 consecutive Camp Timbers seasons, subject to annual updating.