YMCA Camp Seymour Camper Health and Medical History
YMCA OF PIERCE AND KITSAP COUNTIES

the YMCA FOR YOUTH DEVELOPMENT® FOR HEALTHY LIVING FOR SOCIAL RESPONSIBILITY

PLEASE TYPE OR PRINT LEGIBLY AND COMPLETE ALL NON-SHADED AREAS OF THIS FORM

THE INFORMATION ON THIS FORM HELPS YMCA CAMP SEYMOUR STAFF PROVIDE THE BEST CARE FOR YOUR CHILD. WITHHOLDING, MISREPRESENTING, OR INCOMPLETE INFORMATION MAY BE GROUNDS FOR DISMISSAL. PLEASE NOTIFY YMCA CAMP SEYMOUR STAFF IF THERE ARE ANY CHANGES TO THIS FORM.

A MEDICAL EXAM IS REQUIRED ONLY IF THE CAMPER HAS HAD SURGERY, A SERIOUS ILLNESS, AN INJURY THAT HAS LIMITED HIS/HER/THEIR ACTIVITY, OR HAS BEEN HOSPITALIZED IN THE PAST YEAR.

ALL MEDICATIONS (PRESCRIPTION, OVER-THE-COUNTER, AND SUPPLEMENTS) BROUGHT TO YMCA CAMP SEYMOUR MUST BE LISTED ON THIS FORM AND IN THEIR ORIGINAL CONTAINER.

THIS FORM IS FOR YMCA CAMP SEYMOUR HEALTH CENTER USE ONLY; INFORMATION IMPORTANT FOR YOUR CAMPER'S CABIN LEADER MUST BE REPEATED ON THE CAMPER INFORMATION FORM.

OFFICE USE ONLY:

CAMPER INFORMATION

LAST NAME	FIRST NAME		MIDDLE INITIAL
HOME ADDRESS	CITY	STATE	ZIP
HOME PHONE / GENDER ☐ M ☐ F	BIRTHDATE	AGE AT START OF CAMP	GRADE ENTERING IN THE FALL

CAMPER LIVES WITH

☐ Mother ☐ Father ☐ Both: Together ☐ Both: Separately ☐ Other:

FIRST PARENT'S/GUARDIAN'S FULL NAME	HOME PHONE	WORK PHONE	CELL PHONE
SECOND PARENT'S/GUARDIAN'S FULL NAME	HOME PHONE	WORK PHONE	CELL PHONE
HOME ADDRESS (IF DIFFERENT FROM ABOVE)	CITY / STATE		ZIP

ADDITIONAL CONTACTS (IF THE ABOVE ARE UNREACHABLE, THESE WILL BE CONTACTED IN CASE OF CAMPER ILLNESS/BEHAVIOR)

NAME AND RELATIONSHIP	HOME PHONE	WORK PHONE	CELL PHONE
NAME AND RELATIONSHIP	HOME PHONE	WORK PHONE	CELL PHONE

INSURANCE INFORMATION

CARRIER/PLAN NAME	GROUP NO.	INSURANCE ID NO.
NAME OF INSURED		RELATIONSHIP TO CAMPER

MEDICAL TREATMENT AT YMCA CAMP SEYMOUR

UNDER THE RECOMMENDATION OF CAMP'S OVERSEEING PHYSICIAN AND THE SEASONAL HEALTHCARE DIRECTOR, THE BELOW-LISTED OVER-THE-COUNTER MEDICATIONS MAY BE USED. PLEASE CROSS OUT ANY PRODUCTS YOU DO NOT WANT ADMINISTERED:

ADVIL	**ANTIBIOTIC CREAM**	**CLARITIN**	**LIQUID COUGH SUPPRESSANT**	**SUNSCREEN**
ALOE VERA GEL	**BEE STING SWABS**	**COUGHDROPS**	**PEPTO BISMOL**	**TUMS**
ANBESOL	**BENADRYL, 25MG & CREAM**	**HYDROCORTISONE CREAM, 1%**	**SUDAFED DECONGESTANT**	**TYLENOL**

☐ **I GIVE PERMISSION FOR THE ABOVE MEDICATIONS TO BE ADMINISTERED FOR COMMON AILMENTS, EXCEPT AS CROSSED OUT.**

AUTHORIZATION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE

BY MY SIGNATURE, BELOW, I HEREBY GIVE THESE PERMISSIONS TO MEDICAL PERSONNEL SELECTED BY THE CAMP DIRECTOR: ORDER X-RAYS, ROUTINE TESTS, OR OTHER TREATMENT; RELEASE ANY RECORDS NECESSARY FOR INSURANCE PURPOSES; RELEASE A DIAGNOSIS AND PRESCRIPTION TO CAMP STAFF; AND/OR PROVIDE/ARRANGE ANY RELATED TRANSPORTATION NECESSARY FOR MY CHILD.

IF I AM UNREACHABLE, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE CAMP DIRECTOR TO SECURE AND ADMINISTER TREATMENT, INCLUDING HOSPITALIZATION. THIS COMPLETED FORM MAY BE PHOTOCOPIED FOR TRIPS OUT OF CAMP. BOTH SIDES OF THIS FORM ARE CORRECT AND COMPLETE TO BE BEST OF MY KNOWLEDGE, AND THE CAMPER HEREIN DESCRIBED HAS PERMISSION TO ENGAGE IN ALL CAMP ACTIVITIES, EXCEPT AS MAY BE NOTED ON THIS FORM.

PARENT/GUARDIAN SIGNATURE*	DATE (MM/DD/YYYY)
PLEASE PRINT NAME	

*If, for religious reasons, you cannot sign, contact YMCA Camp Seymour for a waiver, which must be signed in order for your camper to attend.

PLEASE COMPLETE BOTH SIDES OF THIS FORM TO ENSURE INFORMATION IS COMPLETE

HEALTH HISTORY (PLEASE CHECK ALL THAT APPLY)

HAS/DOES YOUR CHILD:

- ☐ 1. Had any recent injury/illness/infectious disease?
- ☐ 2. Have a chronic or recurring illness/condition?
- ☐ 3. Ever been hospitalized?
- ☐ 4. Ever had surgery?
- ☐ 5. Have frequent headaches?
- ☐ 6. Ever had a head injury?
- ☐ 7. Ever been knocked unconscious?
- ☐ 8. Wear glasses, contacts, other eyewear?
- ☐ 9. Ever had frequent ear infections?
- ☐ 10. Ever passed out during/after exercise?
- ☐ 11. Ever been dizzy during/after exercise?
- ☐ 12. Ever had chest pain during/after exercise?
- ☐ 13. Ever had seizures?
- ☐ 14. Ever had high blood pressure?
- ☐ 15. Ever been diagnosed with a heart murmur?
- ☐ 16. Ever had back problems?
- ☐ 17. Ever had problems with joints (e.g., knees, ankles)?
- ☐ 18. Have an orthodontic appliance being brought to camp?
- ☐ 19. Have any skin problems (e.g., itching, rash, acne)?
- ☐ 20. Have diabetes?
- ☐ 21. Have asthma?
- ☐ 22. Had mononucleosis in the past 12 months?
- ☐ 23. Had problems with diarrhea/constipation?
- ☐ 24. Have problems with sleepwalking?
- ☐ 25. If female, have an abnormal menstrual history?
- ☐ 26. Have a history of bedwetting?
- ☐ 27. Have an eating disorder?
- ☐ 28. Have ADD or ADHC?
- ☐ 29. Had a physical exam in the past year?
- ☐ 30. Traveled abroad in the past month?
- ☐ 31. Ever had emotional difficulties for which professional help was sought?

EXPLAIN ANY "CHECKED" ANSWERS, NOTING THE QUESTION NUMBER(S)

ALLERGIES (MEDICATION, FOOD, ETC.)

ALLERGEN	REACTION AND MANAGEMENT OF REACTION

IMMUNIZATIONS

INDICATE THE MONTH AND YEAR OF THE LAST IMMUNIZATION/BOOSTER, OR ATTACH A COPY OF THE OFFICIAL RECORD

TETANUS	MEASLES/MUMPS/RUBELLA	HEPATITIS A	DIPHTHERIA/PERTUSSIS (DtaP/DT)
CHICKEN POX	MENINGITIS	HEPATITIS B	OTHER:

MEDICATIONS

PLEASE LIST ALL MEDICATIONS BROUGHT TO YMCA CAMP SEYMOUR (ATTACH ADDITIONAL PAPER AS NECESSARY). KEEP MEDICATIONS IN THEIR ORIGINAL PACKAGING – ORIGINAL PACKAGING FOR PRESCRIPTION MEDICATION MUST IDENTIFY THE PRESCRIBING PHYSICIAN, MEDICATION NAME, DOSAGE, AND FREQUENCY OF ADMINISTRATION. PLEASE CALL IN ADVANCE IF A MEDICATION OR DOSAGE HAS CHANGED IN THE PAST THREE MONTHS.

☐ **THIS CAMPER TAKES NO ROUTINE MEDICATIONS** ☐ **THIS CAMPER TAKES MEDICATIONS AS FOLLOWS:**

NAME OF MEDICATION NO. 1			REASON FOR TAKING		SIDE EFFECTS		
TIME	DOSAGE 1	TIME	DOSAGE 2	TIME	DOSAGE 3	TIME	DOSAGE 4

NAME OF MEDICATION NO. 2			REASON FOR TAKING		SIDE EFFECTS		
TIME	DOSAGE 1	TIME	DOSAGE 2	TIME	DOSAGE 3	TIME	DOSAGE 4

NAME OF MEDICATION NO. 3			REASON FOR TAKING		SIDE EFFECTS		
TIME	DOSAGE 1	TIME	DOSAGE 2	TIME	DOSAGE 3	TIME	DOSAGE 4

OTHER

PLEASE PROVIDE ANY ADDITIONAL INFORMATION ABOUT YOUR CAMPER, SUCH AS: THEIR GENERAL BEHAVIOR; THEIR PHYSICAL, EMOTIONAL, OR MENTAL HEALTH; ANY SIGNIFICANT LIFE EVENTS THAT MIGHT AFFECT BEHAVIOR; AND/OR DIETARY/OTHER RESTRICTIONS

FAMILY PHYSICIAN'S NAME	PHONE
FAMILY DENTIST'S/ORTHODONTIST'S NAME	PHONE