



Stevens Point Area YMCA

Child Care/Day Camp – Health History and Care Form

FULLY COMPLETE ALL SECTIONS of this REQUIRED Health and Care Form and return to:
Stevens Point Area YMCA, Child Development Office, 1000 Division Street, Stevens Point, WI 54481 (715) 342-2999

First Day of Attendance: _____

Participant Name _____ Birth Date _____ Age _____ M or F

Street Address _____
Street *City* *State* *Zip*

Home Phone _____ School _____ Grade ____ Height _____ Weight _____

Parent/Guardian Name _____ **Parent/Guardian Name** _____

Home Address _____ Home Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Workplace & Ph. # _____ Workplace & Ph. # _____

Day/Cell Ph. _____ Home Ph. _____ Day/Cell Ph. _____ Home Ph. _____

Email _____ Email _____

Please Indicate any Custody Issues _____

Emergency Contacts (other than Parent/Guardian) and Persons Authorized to Pick Up Child.

Emergency Contact Name _____ **Emergency Contact Name** _____

Relationship to Child _____ Relationship to Child _____

Home Address _____ Home Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Workplace _____ Workplace _____

Day Ph. _____ Home Ph. _____ Day Ph. _____ Home Ph. _____

Participant's Physician _____ Phone _____
Dr. Name/Facility *Office Address*

Participant's Dentist _____ Phone _____
Dr. Name/Facility *Office Address*

Insurance Information: Is Participant covered by family medical/hospital insurance? ___ YES ___ NO

Carrier or Plan Name _____ Group # _____

Carrier Address & Phone # _____

Name of Insured _____ Relationship to Participant _____

Emergency Treatment Authorization: In the event I cannot be reached in an emergency, I authorize the YMCA staff to transport to and/or secure from any licensed hospital, physician and/or medical personnel any emergency care or treatment deemed necessary for my child. I agree that I will be responsible for the payment of any and all medical services rendered.

Signature of Parental/Guardian _____ **Date** _____

OVER

Participant Name _____ **Birth Date** _____ **Age** _____ **M or F** _____

HEALTH CONDITIONS: (Check any that apply to the participant and explain below, include severity.)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Cerebral Palsy/Motor |
| <input type="checkbox"/> Bed-wetting | <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Joint/Bone Problems | <input type="checkbox"/> Picky Eater |
| <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Head/Neck/Back Injuries | <input type="checkbox"/> Vegetarian |
| <input type="checkbox"/> Warts | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy/Convulsions/Seizures | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Visual Impairment/Glasses... | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Hearing Impairment/Aids... | <input type="checkbox"/> Other |
| <input type="checkbox"/> Abnormal Menstruation | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Speech Impairment | <input type="checkbox"/> Other |
| <input type="checkbox"/> Homesickness | <input type="checkbox"/> Frequent Nose Bleeds | <input type="checkbox"/> Learning Disability | |
| <input type="checkbox"/> Doesn't Swim (describe) | <input type="checkbox"/> Bleeding Clotting Disorder | <input type="checkbox"/> ADD or ADHD | |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Cognitive Disability | |
| <input type="checkbox"/> Exercise Induced Difficulties | <input type="checkbox"/> Emotional/Behavior Disorder | <input type="checkbox"/> Chronic Illness/Condition | |

Give details including triggers, signs/symptoms, care procedures and when to call parent and/or 911 for any conditions checked above: _____

ALLERGIES Describe reaction, management instructions and when to call parent and/or 911.

Medications (list)

Foods (list)

Insects, Animals, Plants...

MEDICATIONS (Please name and describe reason for taking.)

Medication Name	Dosage (tabs & mg)	Times Taken	Reason for Taking
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Will participant medication need to be taken during this program? Yes No Maybe *If yes or maybe a Authorization to Administer Medication form must be completed. All Medications are required to be in original containers and be clearly labeled.*

List and describe any other participant **Health Conditions/Disorders/Impairments/Diseases/Illnesses/Major Surgeries/Special Needs and indicate if there are any Restrictions:** _____

*** A copy of participant's immunization records or provided form must be attached.**

I hereby state that the information I have provided is accurate and complete. I understand that it is my responsibility to provide any changes/updates regarding emergency and health information to the YMCA. I further understand that failure to provide accurate, complete, and updated information may jeopardize my child's participation in this program.

Participant's Name - Please Print **Signature of Legal Parent/Guardian** **Date**

Review dates: _____