



YMCA Camp Glacier Hollow – Stevens Point Area YMCA Resident Camp/Trip Health History and Examination Form

1000 Division Street
Stevens Point, WI 54481
(715) 342-2980 Fax (715) 342-2987

Camp Session Name: _____

Dates of Session: _____

This form, except for the Physical Examination is to be filled in completely by a parent/guardian if camper/participant is under 18 years of age. A current Health History (pages 1-3) is required each year. The Physical Examination (page 4) is required to have been performed by a Licensed Medical Provider within 24 months prior to camp/trip. You may attach a copy of such a physical exam to our form. *Please print or type clearly.*

• **Participant Name** _____ Birth Date _____ Age at Camp _____

Street Address _____
Street City State Zip

Home Phone _____ School _____ Grade _____ Male Female

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

Home Address _____ Home Address _____

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

Workplace _____ Workplace _____

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

Email _____ Email _____

Please Indicate any Custody Issues _____

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

Relationship to Participant _____ Relationship to Participant _____

Home Address _____ Home Address _____

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

Workplace _____ Workplace _____

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

• **Insurance Information:** Is Camper/Participant covered by family medical/hospital insurance? YES NO
Please include a copy of insurance card.

Carrier or Plan Name _____ Group # _____

Carrier Address & Phone # _____

Name of Insured _____ Relationship to Participant _____

Authorization for Health Care: This health history is correct and accurately reflects the health status of me or this participant. I or this participant has permission to participate in all camp activities except as noted. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of me or the participant 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 me or this participant. I understand the information on this form will be shared on a "need to know" basis with staff. I give permission to photocopy this form. The camp has permission to obtain a copy of my or this participant's health record from providers who treat me or this participant and these providers may talk with the staff about me or this participant's health status.

Signature of Custodial Parent/Guardian _____ **Date:** _____ **Relationship to Participant:** _____



HEALTH HISTORY

Participant Name _____

Birth Date _____ Age _____ M or F

• HEALTH/PHYSICAL CONDITIONS: (Check any that apply to the camper/participant and explain below)

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

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

Has camper/participant had any recent injury, surgery, illness, or contagious/infection disease? Yes No
If yes, please describe: _____

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

Medications (list)

Foods (list)

Insects, Animals, Plants...

• RESTRICTIONS or Other things we forgot to ask: List and describe any restrictions or limitations including: Dietary, Health Conditions (physical, behavioral, emotional, mental), Impairments, Other Illnesses, Major Surgeries, Special Needs and indicate if there are any adaptations that could be made: _____

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

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



HEALTH HISTORY

Participant Name _____

Birth Date _____ Age _____ M or F

• **MEDICATIONS:** State law requires that **ALL MEDICATIONS/VITAMINS** brought to camp be in their original container, be clearly labeled, and include instructions from the prescribing physician (see Important Notice in the final camp mailing for details regarding camper/participant medication and vitamins). Please list all medications routinely/currently used. Attach additional pages if necessary. Parent/guardian must give written permission to give any medications if the camper/participant is under 18.

Medication Name	Dosage # of mg & tabs	Administer (please circle)	Time(s) (please circle) <i>MEDS are typically given after meals at these times:</i>
#1		PRN Daily	9am 1pm 4pm 7pm Bed other: _____
Reason for taking and special instructions:			
#2		PRN Daily	9am 1pm 4pm 7pm Bed other: _____
Reason for taking and special instructions:			
#3		PRN Daily	9am 1pm 4pm 7pm Bed other: _____
Reason for taking and special instructions:			
#4		PRN Daily	9am 1pm 4pm 7pm Bed other: _____
Reason for taking and special instructions:			
#5		PRN Daily	9am 1pm 4pm 7pm Bed other: _____
Reason for taking and special instructions:			

AUTHORIZATION TO GIVE MEDICATIONS

I hereby give permission to the Camp Health/Trip Staff to give me or the participant named on this form the medications (as directed) listed above and on any additional page.

Signature _____ Date _____

I hereby give permission to the Camp Health/Trip Staff to give me or the participant named on this form over-the-counter camp medications (as directed) in the event of minor pain/ailment (i.e. headache, stomach ache, sun protection, insect bites, etc...).

Signature _____ Date _____

• **IMMUNIZATION History:** Provide the month/year for each immunization. Starred (*) immunizations must be current.

Copies of immunization forms from health-care providers or state government are acceptable, please attach to this form.

Immunization	Dose 1 month/year	Dose 2 month/year	Dose 3 month/year	Dose 4 month/year	Dose 5 month/year	Recent Dose month/year
*Diphtheria, tetanus, pertussis (DTaP) or (TdaP)						
*Tetanus booster (dT) or (TdaP) (age 12 or older)						
*Mumps, measles, rubella (MMR)						
*Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)			<input type="checkbox"/> Had Chicken Pox Date: _____			
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) Test Date:		<input type="checkbox"/> +pos	<input type="checkbox"/> -neg			

*If participant has not been fully immunized, please sign the following statement: I understand and accept the risks to me or my child from not being fully immunized.

Signature of Custodial Parent/Guardian _____

Date: _____

Relationship to Participant: _____



PHYSICAL EXAM

Participant Name _____

Birth Date _____ Age _____ M or F

If the participant attended a previous camp/trip with YMCA Camp Glacier Hollow within 24 months we can pull the exam and use it this year.
Session Name _____ Dates _____

This page of the form is to be completed by a Licensed Physician within 24 months of the camper/participant's arrival at camp/trip. You may attach a copy of such a physical exam or sports exam to our form. Physician should also confirm the camper/participant Health History (pages 1-3).

The object of this examination is to determine that the individual:

1. Is physically/emotionally fit to engage in camp activities without harm to him/herself and others.
2. Does not have any contagious or infectious condition that could be conveyed to others.

Participant:

Exam Date _____ Weight _____ lbs Height _____ ft _____ in Pulse _____ BP _____/_____

The camper/participant is under the current care or treatment: _____

Treatment to be continued at camp (i.e. medications, diet, etc...): _____

Known Allergies: _____

Restrictions/limitations on camper/participant activity, swimming, diet, etc: _____

<p>In your opinion, is the camper/participant able to participate in an active camp program? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>I have reviewed the Participant Health History and have discussed the camp program with the participant's parent(s)/guardian(s).</p> <p>Name of Licensed Medical Provider & Title (print): _____ Signature: _____</p> <p>Office Name _____ Phone: _____</p> <p>& Address: _____ Date: _____</p>	
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Health Screen to be completed at Camp Check-In (Camp Use Only!)

CABIN:	Loon Haunt	Bear Cave	Turtle Shell	Fawn Hall	Outpost	On Trip
Physical Exam:	Temperature:	Hair:	Throat:	Eyes:	Other:	
Additional Observations & any recent household illnesses:						
Medications (on page 3) confirmed and given to Health Staff:						
Updates to Health History:						

Signature of Health Staff: _____

DATE: _____

Signature of Parent/Guardian If Needed: _____