



YMCA Camp Glacier Hollow - Stevens Point Area YMCA Resident Camp/Tripping Health History Form



FULLY COMPLETE ALL SECTIONS of this YEARLY REQUIRED Health and Care Form and return to:
1000 Division Street, Stevens Point, WI 54481 715-342-2980 Fax 715-342-2987

Camp Session Attending: _____

Participant Name _____ Birth Date _____ Age _____ M 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

Emergency Contact Name _____ Emergency Contact Name _____

Relationship to Participant _____ Relationship to Participant _____

Day/Cell Ph. _____ Home Ph. _____ Day/Cell 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 _____ Member ID# _____ Group# _____

Carrier Address & Phone # _____

Name of Insured & Birth Date _____ Relationship to Participant _____

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 month/year
*Diphtheria-Tetanus-Pertussis (DTP, DTaP, DT)						
*Tetanus Booster (dT) or (TdaP)						
*Measles-Mumps-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			

OVER

Participant Name _____ Birth Date _____ Age _____ M 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"/> Does participant have a School IEP? |
| <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: List and Describe reaction/symptoms, management instructions and when to call parent or 911.

Medications: _____
 Foods: _____
 Insects, Animals, Plants ... _____

RESTRICTIONS or Other things we forgot to ask: List and describe any restrictions or limitations including: Recent injury/illness/infection, 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: _____

MEDICATIONS: All Medications/Vitamins are REQUIRED to be in original containers, be clearly labeled and include written instructions. Attach additional pages as needed.

Medication Name	Dosage (tabs & mg)	Circle Time(s) to be Taken or write "PRN"(only as Needed)	Reason for Taking:
1. _____	_____	9am 1pm 4pm 7pm Bed other:_____	_____
2. _____	_____	9am 1pm 4pm 7pm Bed other:_____	_____
3. _____	_____	9am 1pm 4pm 7pm Bed other:_____	_____
4. _____	_____	9am 1pm 4pm 7pm Bed other:_____	_____
5. _____	_____	9am 1pm 4pm 7pm Bed other:_____	_____

Special Instructions: _____

____ P/G Initials I hereby give permission to the YMCA Staff to give participant the medications (as directed) listed above and on any additional page. I also give permission to the YMCA Staff to give the participant over-the-counter camp medications (as directed) in the event of minor pain/ailment (i.e. headache, stomach ache, sun protection, insect bites, etc...).

____ P/G Initials 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 to the YMCA. I further understand that failure to provide accurate, complete, and updated information may jeopardize participation in this program. If participant has NOT been fully immunized – I understand and accept the risks from not being fully immunized.

____ P/G Initials In the event that I or emergency contact listed cannot be reached in an emergency, I give my consent for YMCA staff to act in my behalf in granting permission for participant to receive emergency treatment. I will be responsible for the payment of any and all medical services rendered. The camp has permission to obtain a copy of participant's health record from providers who treat participant and these providers may talk with the staff about participant's health status.

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