Stevens Point Area YMCA

School Age/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 ❑ 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 _____

Place of Employment and Phone # _____ Place of Employment and Phone # _____

_____ _____

Cell Ph._____ Home Ph. _____ Cell Ph._____ Home Ph. _____

Cell Service Provider (for ER txt) _____ Cell Service Provider (for ER txt) _____

Email Where Reachable While Child is in Care: Email Where Reachable While Child is in Care:

_____ _____

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 _____

Place of Employment and Phone # _____ Place of Employment and Phone # _____

_____ _____

Cell Ph._____ Home Ph. _____ Cell Ph._____ Home Ph. _____

Cell Service Provider (for ER txt) _____ Cell Service Provider (for ER txt) _____

Email Where Reachable While Child is in Care: Email Where Reachable While Child is in Care:

_____ _____

Participant Physician _____ Phone _____
Dr. Name/Facility Office Address

Participant 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 _____ 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 Parent/Guardian _____ **Date** _____

OVER

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

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

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

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

_____

_____

Identify any YMCA staff that you have given specialized instructions/training to: _____

ALLERGIES Describe reaction/symptoms, management instructions and when to call parent 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 Name – Please Print | Signature of Parent/Guardian | Date

Review dates: _____ _____ _____ _____ _____