



# 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 715-342-2999 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 \_\_\_\_\_  
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