



Frost Valley YMCA

Student Health Information Form



To be completed by the parent or guardian:

Student's name: _____ Birth Date: _____

Parent or Guardian: _____

Home address: _____

Phone number (home): _____ (work): _____

Family Doctor: _____ Phone: _____

In an emergency, if unable to reach parent, contact

Name: _____ Phone: _____

Name: _____ Phone: _____

Health History: Please check all that Apply

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Glasses/contact Lenses | <input type="checkbox"/> Heart Disease/Defect | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Other: please explain: | | |

Allergies: Please check all that Apply

- | | | | |
|--|--------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulf | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Animal dander | <input type="checkbox"/> Dairy | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Peanut/Nut |
| <input type="checkbox"/> Other _____ | | | |

Diet Restrictions

- | | | | |
|-------------------------------------|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Dairy Products | <input type="checkbox"/> Nuts/Peanuts | <input type="checkbox"/> Other _____ |
|-------------------------------------|---|---------------------------------------|--------------------------------------|

Immunizations: What is the date of last tetanus shot? _____

If you have any doubts that your child is in good health, have him/her checked by your family doctor and forward the report to the school. Please do not send your child to Frost Valley YMCA if he/she has cold or flu symptoms.

Medications: Students may not have any medications (pill or oral liquid) in his/her possession. This includes over the counter medications like Tylenol®. All medications must be given to and be held by a school representative, or the camp nurse, who will administer medications according to the physician's written instructions. If your child is required to take ANY medication while at Frost Valley YMCA complete the enclosed Medication Permission Request Form.

I am familiar with the program and the general nature of activities planned for my son/daughter during their trip to the Frost Valley YMCA, and to the best of my knowledge the above information is correct and my child is capable of participating in and has permission to engage in all camp activities.

Signature Parent or Legal Guardian: _____ **Date** _____

Over Please



Frost Valley YMCA

Student Waiver of Liability



Signature required for student to participate at Frost Valley YMCA

I hereby accept any and all responsibility for, and assume the risk of any and all injury or damage to my dependent children which might arise directly or indirectly as a result of, and or participation in the Frost Valley YMCA program. I hereby expressly release, discharge and hold harmless from any liability whatsoever the Frost Valley YMCA and all employees and volunteers in their capacities as representatives of the YMCA, except for injuries caused intentionally, or by willful misconduct. I certify that I am familiar with the contents of this release, that I have read and understand the same, and that it is my intention by signing this release that the same be binding not only on me, but my heirs, administrators, executors, successors and assigns.

Signature Parent or Legal Guardian: _____ Date _____



Frost Valley YMCA

Student Model and Statement Release



Signature required for student to participate at Frost Valley YMCA

Periodically, Frost Valley YMCA uses photos and statements made by participants in the Frost Valley YMCA programs for newsletter, fund raising efforts, brochures and articles about Frost Valley YMCA. All photos and statements are used with reasonable judgment for purposes directly relating to the operations of Frost Valley YMCA. This signed form gives Frost Valley YMCA permission by the signer to utilize participant photos or statements for the purposes mentioned above.

Signature Parent or Legal Guardian: _____ Date _____



Frost Valley YMCA

Chaperone Health Information Form



Name: _____ Birth Date: _____

Home address: _____

Phone number (home): _____ (work): _____

Family Doctor: _____ Phone: _____

Emergency Contact Information:

Name: _____ Phone: _____

Name: _____ Phone: _____

Health History: Please check all that Apply

- Heart Disease/Defect Seizure Disorder Diabetes Asthma
- Pneumonia Headaches Hearing Loss Glasses/contact Lenses
- Other: please explain: _____

Allergies: Please check all that Apply

- Penicillin Sulfa Asprin Hay Fever
- Animal dander Dairy Insect Stings Peanut/Nut
- Other _____

Diet Restrictions:

- Vegetarian Dairy Products Nuts/Peanuts
- Other _____

Immunizations: What is the date of last tetanus shot? _____

If currently taking any over the counter or prescription medications, please list them below.

Medication	Dosage	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I am familiar with the program and the general nature of activities planned during the trip to the Frost Valley YMCA, and to the best of my knowledge the above information is correct and I am capable of participating in all camp activities.

Signature: _____ Date: _____

Over Please



Frost Valley YMCA

Chaperone Waiver of Liability



Signature required to participate at Frost Valley YMCA.

I hereby accept any and all responsibility for, and assume the risk of any and all injury or damage to my person which might arise directly or indirectly as a result of, and or participation in the Frost Valley YMCA program. I hereby expressly release, discharge and hold harmless from any liability whatsoever the Frost Valley YMCA and all employees and volunteers in their capacities as representatives of the YMCA, except for injuries caused intentionally, or by willful misconduct. I certify that I am familiar with the contents of this release, that I have read and understand the same, and that it is my intention by signing this release that the same be binding not only on me, but my heirs, administrators, executors, successors and assigns.

Signature: _____ **Date:** _____



Frost Valley YMCA

Chaperone Model and Statement Release



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Signature: _____ **Date:** _____



Frost Valley YMCA

Authorization to Consent to Treatment of Minor Temporarily Separated from His/Her Parents



I, the undersigned, parent or legal guardian of _____, a minor, do hereby
(Child's Name)

authorize _____,
(School Name) (Lead Teacher)

as our agent(s) to consent to any diagnostic procedure or medical care which is deemed advisable by, and is to be rendered under the general or special supervision of any licensed physician at the nearest hospital with facilities appropriate to my child's injury/illness.

It is understood that this authorization is given in advance of any specific need for treatment but is given to provide authority on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the physician in the exercise of her/his best judgement may deem advisable.

This authorization shall remain effective until _____, unless sooner revoked in writing delivered by said agent(s).
(day after last date of trip)

Parent/guardian's printed name Signature Date

Telephone: (home) _____ (work) _____

Address: _____



Frost Valley YMCA

Self-Medication Release



For students requiring emergency medications such as inhalers or bee sting kits - please complete this form.

Students requiring emergency medications, limited to inhalers (Albuterol, Proventil, etc.) and auto-injectors (EpiPen®), are permitted to self-carry these medications at Frost Valley. These medications must remain with the student at all times during their visit.

We request that (*child's name*) _____ be permitted to carry the (*check one*) **inhaler (type)** _____ / **EpiPen®**, on her/his person. She/he has been instructed in and understands the medication's purpose, frequency, and appropriate method of use.

Physician's Printed Name

Signature

Date

As I consider him/her responsible, I will not hold Frost Valley YMCA personnel responsible for any problems that may arise with regards to my child's self-administered medication.

Parent's Printed Name

Signature

Date



Frost Valley YMCA

Medication Permission Request Form



Individualized Orders for: _____ D.O.B.: _____ Weight: _____

Allergies: _____

Standard Over-the-Counter/PRN Medications (The following medications are available in the Health Center and will be administered at the discretion of an RN—if approval is indicated by the camper's health care provider.):

Drug Name	Route <i>Please circle preferred formulation(s)</i>	Dosage	Schedule and Indications	Camper Health Care Provider Order		Comments
Tylenol (acetaminophen)	PO (chewable tabs, elixir or tabs)	Per label instructions by age/weight	Q4H PRN for pain or fever > _____-F	Yes	No	
Ibuprofen	PO (chewable tabs, suspension, or tabs)	Per label instructions by age/weight	Q6H PRN for pain or fever > _____-F	Yes	No	
Sudafed (Pseudoephedrin Hydrochloride)	PO (tabs)	Per label instructions by age/weight	Q4H PRN for nasal congestion not to exceed 4 doses in 24 hours	Yes	No	
Larynex Anesthetic Throat Lozenges	PO (lozenges)	Per label instructions by age/weight	Q2H PRN for sore Throat	Yes	No	
Robitussin (Guaficin)	PO (syrup)	Per label instructions by age/weight	Q4H PRN for cough	Yes	No	
Dramamine (dimenhydrinate)	PO (chewable tabs-50mg)	Per label instructions by age/weight	Q6H PRN for motion sickness	Yes	No	
Benadryl (diphenhydramine hydrochloride)	PO (elixir, chewable tabs or pills)	Per label instructions by age/weight	Q6H PRN for allergic reaction (hives, insect bite)	Yes	No	

Prescription Medications *(please complete with patient's current regimen for both scheduled and PRN medications. Use 2nd page if needed)*

Drug Name	Route <i>Please circle preferred formulation(s)</i>	Dosage	Schedule and Indications	Camper Health Care Provider Order		Comments

Health Care Provider Name: _____ Phone #: _____

Address: _____ License #: _____

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____