

# Health History & Examination Form Frost Valley YMCA • 2000 Frost Valley Road, Claryville, NY 12725

The information on this form is not part of the camper acceptance process, but gathered to assist us in identifying appropriate care.

**Health history must be filled out by parents/guardians of minors or by adults themselves.** Update required annually.

**Health exam must be completed by approved licensed medical personnel.**

Name: \_\_\_\_\_ Birth Date \_\_\_\_\_ Age at camp \_\_\_\_\_  
Last First Middle

Home Address \_\_\_\_\_

Social Security Number of Participant \_\_\_\_\_ Gender:  Male  Female

Custodial parent/guardian \_\_\_\_\_ Phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_

Home Address \_\_\_\_\_  
(If different from above) Street Address City State Zip

Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street Address City State Zip

Second parent, guardian, or emergency contact \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street Address City State Zip

Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street Address City State Zip

If not available in an emergency, notify:

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street Address City State Zip

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**PARENT**  **Attach photocopy of front and back of health insurance card to this form.**

## **Mandated by State.**

**Parent/Guardian Authorizations:** This health history is correct and complete to the best of my knowledge. The person herein described has permission to engage in all camp activities except as noted.

### **Consent to Treatment Waiver**

I hereby give my permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests.

I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Frost Valley YMCA to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

I also understand and agree to abide by any restrictions placed on my child's participation in camp activities.

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**PARENT Signature**  **Signature of parent/guardian or adult camper/staffer** \_\_\_\_\_

**Printed Name** \_\_\_\_\_ **Date** \_\_\_\_\_


## **Meningitis Waiver Mandated by State. For children attending ALL programs.**

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp for seven (7) or more days (Including Day Campers). Check one box and sign below.

My child has had the meningococcal meningitis immunization (Menomuneä) within the past 10 years. Date received: \_\_\_\_\_.  
 [Note: The vaccine's protection last for approximately 3 to 5 years. Revaccination may be considered within 3-5 years.]

I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will not obtain immunization against meningococcal meningitis disease.

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**PARENT Signature**  **Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 (Parent/Guardian)

*To avoid waiting in line on registration day, please fill out all forms completely before mailing back to us. Please double check to see that all information is filled in correctly, all boxes are checked, and all signatures are in place.*

# PARENT'S SECTION

## Health History

### Allergies

List all known allergies. Describe reaction and management of reaction.

No known allergies

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### Restrictions

The following restrictions apply to this individual:

#### Dietary

Does not eat red meat

Does not eat pork

Does not eat eggs

Does not eat poultry

Does not eat seafood

Does not eat dairy products

Other \_\_\_\_\_

**Activities** Please explain any (e.g. what cannot be done, what adaptations or limitations are necessary)

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### General Questions (Explain "yes" answers below)

Has/does the participant:	YES	NO		YES	NO
1. Had any recent injury, illness or infectious disease? .....	<input type="checkbox"/>	<input type="checkbox"/>	14. Ever had high blood pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?.....	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever been diagnosed with a heart murmur?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized? .....	<input type="checkbox"/>	<input type="checkbox"/>	16. Have an orthodontic appliance brought to camp? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery? .....	<input type="checkbox"/>	<input type="checkbox"/>	17. Have any skin problems (e.g. itching, rash, acne)? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>	18. Have diabetes?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?.....	<input type="checkbox"/>	<input type="checkbox"/>	19. Have asthma?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>	20. Had mononucleosis in the past 12 months?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts, or protective eye wear? .....	<input type="checkbox"/>	<input type="checkbox"/>	21. Had problems with diarrhea/constipation? .....	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?.....	<input type="checkbox"/>	<input type="checkbox"/>	22. Ever had an eating disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>	23. If female, have an abnormal menstrual history? .....	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	24. Ever had problems with joints (e.g. knees, ankles?).....	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?.....	<input type="checkbox"/>	<input type="checkbox"/>	25. Ever had back problems?.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	26. Ever had emotional difficulties for which professional help was sought?.....	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" answers, noting the number of the question.

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Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

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Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**It is critical that ALL information is completed**

CAMPERS NAME: \_\_\_\_\_  
 Last Name  
 \_\_\_\_\_  
 First Name Middle Name DOB

I examined the above named on \_\_\_\_\_ Exam date must be within 24 months of camp attendance.

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ In my opinion, the above applicant

is,  is not, able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions: \_\_\_\_\_

**Known Allergies:** \_\_\_\_\_

Description of any limitations or restrictions on camp activities: \_\_\_\_\_

**Medications to be administered at camp:**

Please check next to the following medications to authorize their utilization per package instructions for age and or weight:

- Tylenol     Ibuprofen     Sudafed     Larynex     1% Hydrocortisone Cream  
 Robitussin     Dramamine     Benadryl     Bacitracin     Maalox     Sunblock/Sunscreen

Additional medications and or treatments to be administered while at camp:

4 Medication/Treatment Name	Dosage	Frequency/Schedule

**Check box if the participant has had:**

- Measles     Chicken Pox     German Measles     Mumps     Hepatitis     A     B     C

**Please give dates of immunization:**

Vaccine: Dates: ..... Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr

Vaccine: Dates: ..... Mo/Yr Mo/Yr Mo/Yr Mo/Yr

DPT ..... \_\_\_\_\_

Haemophilus Influenza B . \_\_\_\_\_

TD (tetanus/diphtheria) .. \_\_\_\_\_

Hepatitis B ..... \_\_\_\_\_

Tetanus ..... \_\_\_\_\_

Varicella (chicken pox).... \_\_\_\_\_

Polio ..... \_\_\_\_\_

Meningitis..... \_\_\_\_\_

MMR ..... \_\_\_\_\_

TB Mantoux Test Results  Positive  Negative

Measles or..... \_\_\_\_\_

Mumps or..... \_\_\_\_\_

Rubella..... \_\_\_\_\_

Date of last test \_\_\_\_\_

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**PHYSICIAN** Signature of Licensed Medical Personnel: \_\_\_\_\_

**Both Signatures Necessary**

Printed: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

**SELF CARE/SELF ADMINISTRATION**

**Out Trips/Farm/Adventure Campers OR Campers who need to carry Albuterol or an Epi-pen:**

I request that the above named child be permitted to administer his/her medications under the supervision of a counselor. She/he has been instructed in and understands the medication's purpose, frequency, and appropriate method of use.

**PHYSICIAN** \_\_\_\_\_  
 Physician's Printed Name Signature Date

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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 Signature**

\_\_\_\_\_  
 Parent's Printed Name Signature Date

