

# CAMP FITCH YMCA HEALTH FORM 2010 Update

**Parents:** Please give complete information below so the camp is aware of your camper's needs and has the information necessary for appropriate care. Please mail a copy of this form **before your child's first week at camp**, bring a back-up copy with you upon check in and maintain a copy for your own records. If there are changes after you send us the form, please notify the nurse upon arrival at camp.

**Note:** Please return this form with your **CONFIDENTIAL FORM** and **HORSEBACK RIDING FORM** directly to: Camp Fitch YMCA, 12600 Abels Rd, North Springfield, PA 16430 or fax to 814-922-7000

DATES ATTENDING \_\_\_\_\_

Camper Last Name \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_ Nickname \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age while at camp: \_\_\_\_\_ Gender: \_\_\_\_\_

Custodial parent/guardian \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Home address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Second parent/guardian \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Home address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Please indicate who the child lives with \_\_\_\_\_

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If neither of the above are available in an emergency, please notify:

Alternate contact #1: Name \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Alternate contact #2: Name \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

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Name of Family Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of Dentist/Orthodontist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Do you have family medical/hospital insurance? \_\_\_\_\_ If yes, Policy Holders Name \_\_\_\_\_

Employer through which insurance is obtained: \_\_\_\_\_

Carrier: \_\_\_\_\_ Policy or Group # \_\_\_\_\_

Do you have family prescription drug insurance? \_\_\_\_\_ If yes, Policy Holder's Name: \_\_\_\_\_

Carrier: \_\_\_\_\_ Policy or Group # \_\_\_\_\_

Please attach a copy of both sides of your insurance card. Without this attachment, treatment can be delayed.

## IMPORTANT - MUST BE COMPLETED FOR ATTENDANCE

**Parent's Authorization:** This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities, except as noted by the examining physician and/or I. I understand there are some inherent risks in activities at camp and accidents sometimes occur. I understand that the camp fee includes accident insurance that is only supplementary to my insurance. I hereby give permission to the physician selected by the camp director to order x-rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to anesthesia and/or surgery for my child as named above. I agree that after my child is checked in, he or she will remain until the end of the period unless necessary to withdraw due to illness as defined by the camp physician. *I understand that no refunds are given if a child leaves early because of homesickness or for disruptive behavior as decided by the camp director.* I give permission for Camp Fitch YMCA to use photos or videos of my child in promotional literature.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Witness Signature \_\_\_\_\_

Please turn over to complete the form

LAST NAME:

FIRST NAME:

CAMPER NAME \_\_\_\_\_ DATES ATTENDING \_\_\_\_\_

**CAMPER MEDICAL HISTORY - TO BE COMPLETED BY PARENT**

Health History: (check - giving approximate dates).

Allergies

Diseases

\_\_\_\_\_ Frequent ear infections

\_\_\_\_\_ Hay Fever

\_\_\_\_\_ Rheumatic Fever

\_\_\_\_\_ Heart Defect/Disease

\_\_\_\_\_ Poison Ivy etc.

\_\_\_\_\_ Chicken Pox

\_\_\_\_\_ Convulsions

\_\_\_\_\_ Insect Stings

\_\_\_\_\_ Measles

\_\_\_\_\_ Diabetes (onset)

\_\_\_\_\_ Penicillin

\_\_\_\_\_ German Measles

\_\_\_\_\_ Bleeding/Clotting Disorders

\_\_\_\_\_ Other Drugs

\_\_\_\_\_ Mumps

\_\_\_\_\_ Epilepsy (onset)

\_\_\_\_\_ Peanuts

\_\_\_\_\_ Asthma

\_\_\_\_\_ Tonsillitis

\_\_\_\_\_ Other Foods

\_\_\_\_\_ Strep Throat

Other diseases or detail of the above: \_\_\_\_\_

\_\_\_\_\_ Mononucleosis

Operations or serious injuries (dates): \_\_\_\_\_

Chronic or recurring illness or Special Needs: \_\_\_\_\_

(For girls) Has this camper menstruated? \_\_\_\_ If no, has she been told about it? \_\_\_\_ If yes, is her menstrual history normal? \_\_\_\_

Special considerations or suggestions: \_\_\_\_\_

The Camp Fitch Health Center is well stocked with over-the-counter non-prescription medications. Are there any over-the-counter, non-prescription medications or ointments that **SHOULD NOT** be given to your child?

\_\_\_\_\_

**MEDICAL EXAMINATION - TO BE FILLED OUT BY LICENSED PHYSICIAN**

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining ability to engage in strenuous activities. Laboratory tests done at discretion of physician.

**CODE: V = Satisfactory; X = Not satisfactory (explain); O = Not examined**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ Resting Pulse: \_\_\_\_\_

\_\_\_\_\_ Eyes \_\_\_\_\_ Lungs Allergies (please specify): \_\_\_\_\_

\_\_\_\_\_ Glasses \_\_\_\_\_ Abdomen \_\_\_\_\_

\_\_\_\_\_ Ears \_\_\_\_\_ Hernia \_\_\_\_\_

\_\_\_\_\_ Nose \_\_\_\_\_ Extremities General Appraisal: \_\_\_\_\_

\_\_\_\_\_ Throat \_\_\_\_\_ Posture (spine) \_\_\_\_\_

\_\_\_\_\_ Heart \_\_\_\_\_ Skin \_\_\_\_\_

Date of last tetanus vaccine: \_\_\_\_\_

Immunizations are up-to-date: \_\_\_\_ Yes \_\_\_\_ No If No, Reason: \_\_\_\_\_

Recommendations and restrictions while at camp:

Swimming/diving \_\_\_\_\_ Strenuous Activity: \_\_\_\_\_

Other: \_\_\_\_\_ Special Diet: \_\_\_\_\_

Current medications (list name, dosage and time schedule): All medications must be in a correctly labeled original container and given to the nurse at check-in time. **NO MEDICATIONS (PRESCRIPTION OR OVER-THE-COUNTER) WILL BE ALLOWED IN THE CABENT UNLESS AUTHORIZED BY THE NURSE.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have examined this person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted.

**Doctor signs here:** \_\_\_\_\_ **M.D. Date** \_\_\_\_\_

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

**Phone:** (\_\_\_\_\_) \_\_\_\_\_ **Fax:** (\_\_\_\_\_) \_\_\_\_\_