YMCA Camp Winona

Health History Form

898 Camp Winona Rd
DeLeon Springs, FL 32130
386.985.4544
www.CampWinonaYMCA.org

This form must be filled out in its entirety, signed by the camper's parent/guardian, and returned with physical and waivers to the camp office prior to your camper's session (two weeks prior is preferred). Email the completed form to **campwinona@vfymca.org**

Camper's Name_______________________________ Gender ☐ Male ☐ Female

Mailing Address_______________________________ Birthday____/_____/______ Age________

_______________________________ Upcoming Grade____________________

CONTACT INFORMATION IN CASE OF ILLNESS OR INJURY

Camper Lives With_____________________________Relationship To Camper____________________

First Guardian's Name & Email____

Primary Guardian's Phone #________________________Alternate Phone #_________________________

Second Guardian's Name & Email____

Second Guardian's Phone #________________________Alternate Phone #_________________________

Emergency Contact Name__________________________Relation to Camper_________________________

Emergency Contact Phone #________________________Alternate Phone #_________________________

CAMPER MEDICAL INFORMATION

Name of Family Physician_____________________________Phone #___________________________

Name of Family Dentist_______________________________Phone #___________________________

Name of Family Orthodontist___________________________Phone #___________________________

MEDICAL INSURANCE INFORMATION

Camper is covered by family medical/hospital insurance ☐ Yes ☐ No

If yes, please include a copy of your insurance card (both sides)

Insurance Company_____________________________________Phone #___________________________

Subscriber____Policy #___________________________

GENERAL HEALTH HISTORY

Please check if any of the below apply

- ☐ Recent injury, illness, or infectious disease
- ☐ Ever been hospitalized
- ☐ Chronic or recurring illness/condition
- ☐ Ever had surgery
- ☐ Ever had seizures
- ☐ Skin conditions
- ☐ Diabetes
- ☐ Asthma/Wheezing/Shortness of Breath
- ☐ Headaches
- ☐ Fainting/Dizziness
- ☐ Passed out/chest pain during exercise
- ☐ Back/joint problems
- ☐ Regular diarrhea/constipation
- ☐ Frequent ear infections
- ☐ Heart defect/disease
- ☐ Blood disorder (hepatitis, HIV, clotting, etc)
- ☐ Nosebleeds
- ☐ Hypertension
- ☐ Mononucleosis
- ☐ Chicken Pox
- ☐ Measles/German Measles
- ☐ Mumps
- ☐ Sleepwalking or night terrors
- ☐ History of bedwetting
- ☐ Wakes in night to use restroom
- ☐ History of being afraid of the dark
- ☐ History of noise while asleep (snores, talks, etc)
- ☐ Menstruation problems
- ☐ Glasses/Contact lenses
- ☐ Braces, retainers, or other dental items
- ☐ Mental health hospitalization
- ☐ Eating disorders
- ☐ Anxiety
- ☐ Depression
- ☐ Learning disability
- ☐ Attention Deficit Hyperactivity Disorder (ADHD)
- ☐ Tourette's Syndrome
- ☐ Autism Spectrum Disorder (ASD)
- ☐ Behavior Disorder
- ☐ Obsessive Compulsive Disorder (OCD)
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ Pervasive Development Disorder (PDD)
- ☐ Oppositional Defiant Disorder (ODD)
- ☐ Ever had professional help for behavioral or emotional difficulties
- ☐ Traveled outside the country in the past 12 months___________________________________
- ☐ Have any restrictions to activities (what cannot be done/adaptations/limitations necessary)
- ☐ Significant life event that continues to affect Camper's life (abuse, death, family changes, etc)
- ☐ Additional concerns Camp should be aware of (behavior, physical, emotional health, etc)

Please explain all checked items or anything we have forgotten ask___________________________________

____

____

____

____

IMMUNIZATION HISTORY

Please initial one or the other

☐ ________ I hereby verify that my child is current on all immunizations required for school. Please include a current copy of immunizations OR fill out the information below.

☐ ________ If your camper has not been full immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

____

Signature of Parent/Guardian   Date

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Booster Month/Year
Diptheria, tetanus, pertussis (DtaP or TdaP						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenza Type B (HIB)						
Pneumoccal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)						
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) Test	Date:	Negative ☐	Positive ☐			

ALLERGIES Please check if any of the below apply. If checked, please state if the allergy is mild, moderate, or severe AND if the allergy is contact or airborne.

☐ Animal________________
☐ Insect Stings
☐ Medicine_____________
☐ Penicillin
☐ Environmental (Pollen, trees, mold, etc)
☐ Peanut/Tree Nut
☐ Food_________________
☐ Other________________

Severity of reaction and action plan for your camper____

____

____

DIET & NUTRITION Please check if any of the below apply.

☐ Vegetarian
☐ Vegan
☐ No Red Meat
☐ Lactose Intolerant
☐ Dairy-Free
☐ Gluten Free
☐ Other (Nuts, Eggs, Soy, etc)____

MEDICATIONS Please list ALL medications (including over-the-counter and non-prescription) that are taken routinely by the camper. Please bring enough medication to last for the whole week. ALL medication must be in its original packaging that identifies prescribing physician (if prescribed), the name of the medication, dosage, and frequency.

☐ This camper does not take any medication

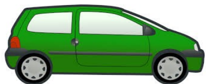
☐ This camper takes routine medication (including vitamins) as follows:

Medication	Dosage	Times Taken	Reasons for taking
		_______ Breakfast _______ Lunch _______ Dinner ______ Bedtime ______ Other _______________	
		_______ Breakfast _______ Lunch _______ Dinner ______ Bedtime ______ Other _______________	
		_______ Breakfast _______ Lunch _______ Dinner ______ Bedtime ______ Other _______________	
		_______ Breakfast _______ Lunch _______ Dinner ______ Bedtime ______ Other _______________	
		_______ Breakfast _______ Lunch _______ Dinner ______ Bedtime ______ Other _______________	
		_______ Breakfast _______ Lunch _______ Dinner ______ Bedtime ______ Other _______________	
		_______ Breakfast _______ Lunch _______ Dinner ______ Bedtime ______ Other _______________	

The following medications may be stocked in our Health Center and are dispensed by our Health Administrators on an as needed basis.

Please cross out any medications which your camper SHOULD NOT be given:

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Antibiotic cream/ointment (Neosporin)
- Antihistamine/allergy medicine (Claritin, Zyrtec)
- Diphenhydramine antihistamine/allergy medicine (Benadryl)
- Bismuth subsalicylate for diarrhea (Pepto-Bismol, Kaopectate)
- Laxatives for constipation
- Aloe Vera lotion or spray
- Calamine lotion
- Hydrocortisone Cream
- Epsom Salt
- Cough drops
- Sore throat spray
- Guaifenesin cough syrup (Robitussin)
- Dextromethorphan cough syrup (Robitussin DM)
- Hydrogen Peroxide
- Pseudoephedrine decongestant
- (Sudafed)
- Phenylephrine decongestant
- (Sudafed PE)
- Rubbing Alcohol
- Sterile eye drops
- Tums
- Other_________________________



AUTHORIZED PICK UP LIST *(in addition to Parents/Guardians on 1st page)*

Name____Relationship:________________________________

Phone #____Alternate Phone #___________________________

Name____Relationship:________________________________

Phone #____Alternate Phone #___________________________

Name____Relationship:________________________________

Phone #____Alternate Phone #___________________________

Name____Relationship:________________________________

Phone #____Alternate Phone #___________________________

Name____Relationship:________________________________

Phone #____Alternate Phone #___________________________

PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE

This health history is correct and accurately reflects the health status of______________________________

(camper to whom it pertains)

S/he has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

____

Primary Guardian Signature Date

FOR CAMP USE ONLY

Any signs/symptoms of illness/injury upon arrival? YES ☐ NO ☐

Does the camper have medications? YES ☐ NO ☐

Does the camper have allergies? YES ☐ NO ☐

Head checked and cleared? YES ☐ NO ☐

Recommendations for Licensed Medical Personnel

FORM 2

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Mail this form to the address below by _______ (date)

To Parent(s)/Guardian(s): Complete this section and give this form (FORM 2) and a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1) to your child's health-care provider for review.

Dates will attend camp: from ____________to___________
Month/Day/Year Month/Day/Year

Camper Name: ____
First Middle Last

☐ Male ☐ Female Birth Date ________________ Age on arrival at camp ______________
Month/Day/Year

Camper home address: ____

____
City State Zip Code

Custodial parent(s)/guardian(s) phone: (______)____________________ (______)______________________

Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.

Camper Name ____________ First ____________ Middle ____________ Last ____________

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. ***Medical personnel:* Cross out those items the camper should *not* be given.**

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Phenylephrine (Sudafed PE)
- Pseudoephedrine (Sudafed)
- Chlorpheneramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimite)
- Calamine lotion
- Bismuth subsalicylate (Pepto-Bismol)
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Calamine lotion
- Aloe

***Medical Personnel:* Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.**

Physical exam done today: ☐ Yes ☐No **(If "No," date of last physical: __________________)**
Month/Day/Year

ACA accreditation standards specify physical exam within the last 24 months.

Weight: ______ lbs Height: _____ft_____in Blood Pressure______/______

Allergies: ☐ No Known Allergies

☐ To foods ***(list)***:

☐ To medications: ***(list)***:

☐ To the environment ***(insect stings, hay fever, etc.– list)***:

☐ Other allergies: ***(list)***:

Describe previous reactions:

Diet, Nutrition: ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions:(describe below)

The camper is undergoing treatment at this time for the following conditions: ***(describe below)*** ☐ None.

Medication: ☐ No daily medications. ☐ Will take the following prescribed medication(s) while at camp: ***(name, dose, frequency—describe below)***

Other treatments/therapies to be continued at camp: ***(describe below)*** ☐ None needed.

Do you feel that the camper will require limitations or restrictions to activity while at camp? ☐ No ☐ Yes

If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)

"I have reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Name of licensed provider (please print): ______________________________Signature: ____________________Title: ____________

Office Address____
Street City State Zip Code

Telephone: (_______)__________________ Date:____________________

(For Camp Use) Cabin or Group______________

(For Camp Use) Session Code(s): ______________

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