

YMCA Camp Eigenberg Health History Form

This form must be filled out completely and signed by camper's parent/guardian and camper and returned to either YMCA location by: July 15

Return To:
Hastings Family YMCA
1430 W. 16th
Hastings, NE 68901

Camper's Name: _____
LAST
FIRST
M.I.

Birthdate: ___/___/___ Age: ___ Gender: _____

Home Address: _____ City _____ State _____ Zip _____

Parent/Guardian #1: _____ Parent/Guardian #2: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Cell Phone : _____ Cell Phone: _____

Emergency Contact (other than parent): _____ Relation to camper: _____

Phone: _____ Cell Phone: _____

Do you carry medical/dental insurance? No Yes Carrier name: _____ Policy #: _____

GENERAL MEDICAL HISTORY (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"/>	9. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	10. Ever had professional help for behavioral or emotional difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have any restrictions to activities (i.e. what cannot be done or adaptations/limitations necessary)	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	12. Dietary restrictions (e.g. vegetarian, vegan, gluten, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
6. Have any skin problems?	<input type="checkbox"/>	<input type="checkbox"/>	13. Additional concerns camp should be aware of (e.g. behavior, physical, emotional health, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
7. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>			
8. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the question (additional space on reverse or attach additional paper if needed):

Name of Dentist/Orthodontist: _____

Phone #: _____

Name of Family Physician: _____

Phone #: _____

HEALTH HISTORY:

	Yes	No	Date
Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart defect/disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding/clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Diseases:

Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	_____
Measles/German Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other:			_____

Allergies: Please check all boxes that apply. Explain camper's reaction on reverse.

	Yes	No	Mild	Mod.	Severe	Contact	Airborne
Horses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food: Peanut	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food: Tree Nut	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Insect Stings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other Drugs: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Contact: experiences reaction when directly introduced to allergen (e.g. eating a food or touching horse).

Airborne: experiences a reaction when indirectly introduced to allergen (e.g. sitting next to someone who has ridden a horse or eaten a food).

Immunizations:

I attest that my child is current on all immunizations required for school: Yes No

Date of last Tetanus shot: Month: _____ Year: _____

MEDICATIONS

Please list all medications, including non-prescription drugs, taken routinely. See parent handbook for instructions if bringing medications.

- This person takes no medications on a routine basis
 This person takes medications as follows: _____

I give permission for camp staff to administer non-prescription medications as needed (HW.9.1):

Yes, with the following exceptions: _____

No, I do not give permission

IMPORTANT—THIS BOX MUST BE COMPLETED AND SIGNED BY PARENT AND CAMPER FOR ATTENDANCE

This health history is correct as far as I know and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the Camp to order X-rays, routine tests, treatment, and necessary transportation for me/or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp to secure and administer treatment, including hospitalization, for my child named above. I understand the YMCA does not carry health and accident insurance and that I, as Guardian, will be responsible for any bills incurred (HW.9.1). I also give permission for the Hastings Family YMCA to transport my child off the camp property for the purpose of medical care and program activities. The Hastings Family YMCA has my permission to use any photographs or videos of my child in promotional material. The completed forms may be photocopied for trips out of camp.

X Signature of Parent/Guardian or staff _____ Date: _____

I also understand and agree with the information provided and to abide with the restrictions placed on my camp activities:

X Signature of Camper _____ Date: _____