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:
June 19th – for camp June 26th-30th

Return To:
Hastings Family YMCA
1220 W. 18th | 1430 W. 16th
Hastings, NE 68901
Or Fax To: 402-434-9208

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

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	☐	☐	_____
Heart defect/disease	☐	☐	_____
Bleeding/clotting disorders	☐	☐	_____
Hypertension	☐	☐	_____
Mononucleosis	☐	☐	_____
Diseases:			
Chicken Pox	☐	☐	_____
Measles/German Measles	☐	☐	_____
Mumps	☐	☐	_____
Hepatitis	☐	☐	_____

Other:_____
_____
_____
_____

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

	Yes	No	Mild	Mod.	Severe	Contact	Airborne
Horses	☐	☐	☐	☐	☐	☐	☐
Food: Peanut	☐	☐	☐	☐	☐	☐	☐
Food: Tree Nut	☐	☐	☐	☐	☐	☐	☐
Food:_____			☐	☐	☐	☐	☐
Other:_____			☐	☐	☐	☐	☐
Other:_____			☐	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐	☐		
Insect Stings	☐	☐	☐	☐	☐		
Penicillin	☐	☐	☐	☐	☐		
Other Drugs:_____			☐	☐	☐		

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:_____

Additional Information:_____
_____
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Health Care Recommendations by Licensed Medical Personnel (Optional, but encouraged) (HW.6.1)

I have examined _____ Date of last examination:_____
Participant Name

In my opinion, the above named is ☐able / ☐not able to participate in an active camp program.

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

Current treatment at the time of examination includes:_____
_____

Recommendations and Restrictions at Camp:

Treatment to be continued at camp: _____
_____

Medications to be administered at camp: _____
_____

Any medically prescribed meal plan or dietary restrictions, including any known food allergies: _____
_____

Known allergies: _____
_____

Description of any limitations or restriction on camp activities: _____
_____

Additional information for the health care staff at camp: _____
_____

FOR CAMP STAFF USE ONLY

Is all of the information current?	YES	NO	Explain: _____ _____
ASK THE CAMPER: How are you feeling today? Have you been sick in the last two days?	YES	NO	Explain: _____ _____
Has camper been seen by a doctor within 2 weeks?	YES	NO	Explain: _____ _____
Does the camper have any medications	YES	NO	(If yes, meds must be checked in to health specialist)

Screened __/__/__ Check-In OR Time_____ am/pm By _____