

YMCA OF SILICON VALLEY | Resident/Travel Camp Health History Form

(Complete one form per child - ALL pages - Must be submitted 3 weeks before camper's arrival)

Mail to: YMCA Camp Campbell, 16275 Highway 9, Boulder Creek, CA 95006, or fax to 831-338-9486

Camper's Name: Last

Child's Name: _____ M F Age (during camp) _____ Birth Date ___ / ___ / ___
Address: _____ Apt.# _____ City _____ Zip _____ Grade _____
Parent/Guardian 1: _____ Parent/Guardian 2: _____
Home Phone #: _____ Home Phone #: _____
Employed by: _____ Employed by: _____
Occupation: _____ Occupation: _____
Business Phone: _____ Business Phone: _____

EMERGENCY INFORMATION

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

INFO REQUIRED BY STATE LAW If you have insurance

Health Insurance Co.: _____
Policy Number: _____
Family Physician: _____
Phone: _____
Family Dentist: _____
Phone: _____

VACCINES (APPROX DATE IMMUNIZED)

DPT: _____ Measles: _____
Tetanus: _____ Mumps: _____
Oral Polio: _____ Rubella: _____

MEDICAL INFORMATION PAST OR PRESENT (PLEASE CHECK)

Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	ADD/ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Defect/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head Lice (recent)	<input type="checkbox"/> Yes <input type="checkbox"/> No	German Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recent Hospitalization	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bed-wetting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychological Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Currently under Dr. care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleepwalking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No		

For each Yes, please explain: _____

ALLERGIES & SPECIAL NEEDS (PLEASE CHECK)

Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bee Stings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oak/Ivy Poisoning	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bee Sting Kit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Foods	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other insects or animals	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Current Medications to be continued at camp (dosage/frequency): _____

Dietary Restrictions? : Yes No _____

Any reason to restrict full activity including swimming, long hikes, strenuous physical games?: Yes No
If Yes, please explain: _____

NON-PRESCRIPTION MEDICATIONS I authorize the following medications to be administered as needed:

Tylenol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Benadryl	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pepto Bismol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neosporin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chloraseptic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cough Drops	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ibuprofen	<input type="checkbox"/> Yes <input type="checkbox"/> No	Calamine Lotion	<input type="checkbox"/> Yes <input type="checkbox"/> No

First

Session:

PARENT'S AUTHORIZATION

This health history is correct, so far as I know, and the person herein has permission to engage in all prescribed program activities. I give permission to the physician selected by the YMCA 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 the physician selected by the YMCA to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child named above. We recognize that the participant must follow safety instructions, remain in areas designated by staff and refrain from behavior that is harmful to oneself or others. Failure to adhere to program policies will be cause for participant's dismissal without refund of fees. Images of my child may be used for promotional purposes.

Parent/Guardian Signature ~~X~~ _____ Date _____

CONSENT TO SEARCH CAMPER'S BELONGINGS

In order to prevent harm, maintain order and safety to all campers and staff who are participating in the YMCA of the Silicon Valley camping activities, I (parent) hereby give permission to YMCA staff to search my camper's belongings when there is reasonable suspicion that the camper has possession of illegal or dangerous items (i.e./ weapons, knives, alcohol, illegal drugs, fireworks or explosives) or the camper seriously violates camp rules and evidence of the infraction can be found through a search of the camper's personal belongings. To the extent possible, the camper will be present during such a search and the scope of the search will be limited to their personal belongings.

Parent/Guardian Signature ~~X~~ _____ Date _____

MEMO OF UNDERSTANDING (To be read, understood and signed by Camper and Parent)

We welcome you to our YMCA of Silicon Valley camping programs. In order to provide the best possible experience for everyone, there are certain rules and policies that have been established for the health and safety of all involved.

1. The camper agrees to abide by the rules and regulations set by the camp for the health, safety and welfare of all campers.
2. Campers are not allowed to smoke, chew tobacco, possess any smoking materials, alcohol or illegal drugs.
3. All medications/prescribed drugs must be kept in a secure location under the control of the Health Supervisor.
4. Campers are not to possess or use firecrackers or explosives. Campers may not possess weapons of any kind.
5. Willful destruction of property will be the financial responsibility of the camper's parent.
6. Campers may not leave camp property or established boundaries without YMCA staff permission.
7. Continued inappropriate behavior, including threatening, swearing, not following directions, teasing, sexual harassment/intimidation and improper behavior in transportation vehicles, may result in IMMEDIATE DISMISSAL FROM CAMP WITH NO REFUND.
8. The YMCA is not responsible for articles of clothing or personal belongings lost or damaged.

We reserve the right and WILL send ANYONE home (at parents' expense and liability) who violates these rules. It is the responsibility of the parent/guardian to pick up or arrange transportation home for the camper. The camp administrator reserves the right to determine what constitutes a violation of these rules and will enforce them as necessary.

I have read, and understood and will abide by the rules as stated above throughout my stay at camp.

Camper's Signature ~~X~~ _____ Date _____

Parent/Guardian Signature ~~X~~ _____ Date _____

Camper's Name: Last

First

Session:

FOR RESIDENT CAMP AND TRAVEL CAMP ATTENDEES ONLY

All campers are required to have written confirmation of a health examination within 24 months of attending Resident camp or travel camps.

REQUIRED: HEALTH EXAMINATION BY LICENSED PHYSICIAN

Camp is held at an outdoor setting, with programs that are very active, including hiking, games, swimming and traditional camp activities. Your careful consideration is appreciated.

I have examined the child named on this form within the past two years. The examination date was ____/____/____. After examination and my review of his/her health history, it is my opinion that this person is physically able to engage in camp activities, except as noted below.

Is the applicant under the care of a physician for any conditions? Yes No
If yes, please explain:

Any specific activities to be encouraged or limited by physician's advice?:

Any treatment or medications to be continues at camp (please give specific dosages):

Additional health information: _____

Licensed Physician Signature: ~~X~~ _____ Date: _____
Address: _____ Phone: _____
Date of Form Completion: _____ By: _____

Camper's Name: Last _____ First _____ Session: _____