YMCA Camp Independence

2026 Health History and Examination Form

The information on this form is gathered to assist us in identifying appropriate care. Health history must be filled out by parents/guardians of minors or by adults. **Update required annually**. A licensed medical personnel must complete the health exam on the (back page). **NOTE: Please make a copy of this form for your records before sending the original to camp.**

Camper Name _____ Birth date _____ Age at camp _____

Home address _____
Street Address City State Zip

Gender: ❑ Female ❑ Male Height _____ Weight _____ Nickname _____

Custodial parent/guardian _____ Phone _____

Home address _____ Cell _____
If different than above Street Address City State Zip

Business address _____ Phone _____
Street Address City State Zip

Second parent/guardian _____

Home address _____ Cell _____
If different than above Street Address City State Zip

Business address _____ Phone _____
Street Address City State Zip

If there is an emergency at camp, please list who to notify in number order.

#1 Name _____ Relationship _____

Home Phone _____ Cell Phone _____ Other Phone _____

#2 Name _____ Relationship _____

Home Phone _____ Cell Phone _____ Other Phone _____

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? ❑ Yes ❑ No
If so, indicate carrier or plan name _____ Group # _____

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

It is my intention that the camp staff be treated as acting *in loco parentis* for the person herein named as a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event 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 the person named above. This completed form may be photocopied for camp purposes.

Signature of parent or guardian or adult camper _____

Printed Name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper _____ Date _____

*If for religious reasons you cannot sign this form, contact the camp for a legal wavier which must be signed for attendance.

Health History

The following information must be filled out by the parent/guardian or adult camper, or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES:
❑ **Penicillin** ❑ **Latex** If so, what type of a reaction does your camper have? ❑ Anaphylactic ❑ hives ❑ rash
List all other allergies:

_____ _____

_____ _____

_____ _____

Is your camper allergic to bee stings? ❑ **Yes** ❑ **No** If so, what is the camper's reaction when stung? _____

_____

FOOD ALLERGIES: List all known

_____ _____

_____ _____

_____ _____

_____ _____

MENTAL: ❑ Attention Deficit Disorder ❑ Memory Problems ❑ Emotional Problems
❑ Fears (list below) ❑ Learning Difficulties (list below) ❑ **No Concerns**

_____

_____

BEHAVIORAL: ❑ Likes to be the center of attention ❑ Does not acclimate well in groups ❑ Depression
❑ May be stubborn ❑ May be aggressive when upset ❑ Other (list below)
❑ **No Concerns**

_____

_____

Has your camper been diagnosed with any behavior disorders? ❑ **Yes** ❑ **No** If so, please explain. _____

_____

PHYSICAL: ❑ Hydrocephalus ❑ Speech Problems ❑ Does camper have a shunt?
❑ Seizures(specify type below) ❑ Fine Motor Skills ❑ Yes ❑ No Type: _____
❑ Other (list below) ❑ **No Concerns** Last revision (date) _____
Neurosurgeon _____
Phone _____

If camper has a shunt, is the shunt programmable? ❑ Yes ❑ No If yes, what is the valve set at? _____

_____

Seizure History: _____

_____

Gastrointestinal: ❑ Constipation ❑ Feeding problems ❑ Abnormal Stools ❑ Acid Reflux
❑ Impaction ❑ Diarrhea ❑ Polyps ❑ Tube Feeding
❑ Diverticulitis ❑ Other (list below) ❑ **No Concerns**

_____

_____

Respiratory: ❑ Sleep Apnea ❑ Wheezing ❑ Shortness of breath
❑ Asthma ❑ Nebulizer Treatments (how often? _____)
❑ Other (list below) ❑ No Concerns

_____

_____

Muscular/Skeletal: ❑ Bones break easily ❑ Scoliosis ❑ Kyphosis
❑ Muscle weakness ❑ Lordosis ❑ Other (list below)
❑ **No Concerns**

_____

_____

Skin : ❑ Rash ❑ Pressure sores ❑ Insect bites
❑ Ulcers ❑ Cuts or scrapes ❑ **No Concerns**
❑ Other (list below)

Is camper currently being treated for any skin breakdown? _____

_____

Wound Status : ❑ **No wounds present** ❑ **Open wound(s) present** ❑ **Closed wound(s) present**

What is the treatment plan for any current wounds?

_____

_____

Mobility: Camper uses ❑ Wheelchair (__ manual __ electric) ❑ Walker ❑ Crutches ❑ Leg Braces
❑ AFO's ❑ Transfers (__ unassisted __ with assisted-explain below)
❑ Other (list below) ❑ Prosthesis/cast/orthotics

_____

_____

Bladder Management: ❑ Toilet Trained Is camper on a bladder program? ☐ Yes ☐ No
❑ Briefs/Panties If yes, size of catheter _____
❑ Disposable Undies Catheter schedule _____
❑ Pullups ❑ Self Cath ❑Assist Cath ❑ Nurse Cath
❑ Diapers ❑ Needs Assistance (Describe below)
❑ Incontinent pads ❑ Other (list below)

_____

_____

BOWEL MANAGEMENT: Is the camper on a bowel program? ☐ Yes ☐ No If yes, explain ____

_____

❑ Mace How long does the camper sit on the toilet? _____ ❑ Unassisted ❑ Assisted
❑ Digital Stimulation ❑ Suppositories ❑ Laxatives
❑ Cone enema (amount of water _____ How long? _____) ❑ Other (specify below)

_____

PERSONAL CARE: How much of his/her own care can camper perform?_____

❑ Independent Care ❑ Needs Assistance (Describe below)

❑ Females: Date of last menstrual cycle _____
❑ Irregular cycle ❑ Normal cycle ❑ Pads ❑ Tampons

_____

_____

OTHER SPECIAL TREATMENTS:

_____

_____

RESTRICTIONS
The following restrictions apply to this individual.

Dietary
❑ Does not eat red meat ❑ Does not eat pork ❑ Does not eat eggs ❑ Gluten free
❑ Does not eat poultry ❑ Does not eat seafood ❑ Does not eat dairy products ❑ No peanuts
❑ Other (describe) _____

Explain any restrictions with activities _____

_____

_____

Which of the following has the participant had?
❑ Measles ❑ Chicken Pox ❑ German measles ❑ Mononucleosis
❑ Mumps ❑ Hepatitis A ❑ Hepatitis B ❑ Hepatitis C

All immunizations required for school are up to date. ☐ YES ___ NO (exemption letter must accompanying this form).

Date of last Tetanus booster: _____

*The CDC recommends a tetanus booster every 10 years. While the YMCA does not require tetanus vaccinations, a lack of one could result in an early departure from camp in case of injury.

YMCA Camp Independence is requiring ALL forms to be completed and sent in no later than 3 weeks prior to your camper's session starting. Please Initial here:

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

_____

_____

_____

_____

_____

Can participant swim? ☐ Strong swimmer ☐ Needs Assistance ☐ Non swimmer ☐ Wears lifejacket or needs floaters

Name of Family Physician:_____ Phone _____
Address _____

Name of dentist/orthodontist:_____ Phone _____
Address _____

MEDICATION INFORMATION

Please list all medications that the participant takes routinely, this includes over-the-counter, non-prescription or prescription drugs. Be sure to bring enough medication to last the entire time the participant is at camp. Allow for spillage by sending an extra couple doses. **Medications must be in their original packaging or bottles that identify the prescribing physician, the name of the medication, the dosage and the frequency of administration.** The original containers will be returned at the end of the camp session.

Name of Medication Example: Oxybutinin	**Strength** 5 mgm	**Frequency** 1 tab, 3 times a day	**Special Instructions** Crush tab and take with juice

☐ Camper does not take any medication

The information provided on this form is true and correct to the best of my knowledge.

Parent/Guardian/ Self Signature _____ Date _____

Printed Name: _____

CAMP INDEPENDENCE MEDICAL FORM

Must be signed by a physician

Parents are not to fill out the form for the Physician to sign; medical staff must fill out form.

Physician's Statement: I have examined _____ and find him/her physically able to attend camp. I understand that the treatment plan will be followed at camp, unless other orders are received.

BP _____ Weight _____ Height _____

Physical Exam

General Appearance: _____

Lungs_____

Abdomen_____

Neurological_____

Skin_____

Heart_____

Extremities_____

Physical Exam significant findings/limitations:

_____

_____

_____

Please describe any current medical problems:

_____

_____

_____

Additional information for health care team staff at the camp:

_____

_____

_____

Treatment to be continued at the camp:

_____

_____

_____

Signature of Physician _____ Date of exam _____

Printed Name: _____ Phone _____

Address _____

Signature of Reviewing Advising Physician _____ *Date*_____