



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA Camp Independence

2023 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
 Fears (list below)

Memory Problems
 Learning Difficulties (list below)

Emotional Problems

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)

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

PHYSICAL: Hydrocephalus
 Seizures(specify type below)
 Other (list below)

Speech Problems
 Fine Motor Skills

Does camper have a shunt?
___ Yes ___ No Type: _____
Last revision (date) _____
Neurosurgeon _____
Phone _____

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

Gastrointestinal: Constipation
 Impaction
 Diverticulitis

Feeding problems
 Diarrhea
 Other (list below)

Abnormal Stools
 Polyps

Acid Reflux
 Tube Feeding

Respiratory: Sleep Apnea Wheezing Shortness of breath
 Asthma Nebulizer Treatments (how often? _____)
 Other (list below)

Muscular/Skeletal: Bones break easily Scoliosis Kyphosis
 Muscle weakness Lordosis Other (list below)

Skin : Rash Pressure sores (___ Reddened ___ Open area ___ Drainage)
 Ulcers Cuts or scrapes
 Other (list below) Insect bites

Is camper currently being treated for any skin breakdown? _____

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 Briefs/Panties Disposable Undies Pullups Diapers Incontinent pads
Is camper on a bladder program? ___ Yes ___ No
If yes, size of catheter _____
Catheter schedule _____
 Self Cath Assist Cath Nurse Cath
 Needs Assistance (Describe below)
 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 poultry
- Other (describe) _____
- Does not eat pork
- Does not eat seafood
- Does not eat eggs
- Does not eat dairy products
- Gluten free
- No peanuts

Explain any restrictions with activities _____

Which of the following has the participant had?

- Measles
- Mumps
- Chicken Pox
- Hepatitis A
- German measles
- Hepatitis B
- Mononucleosis
- Hepatitis C

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

Date of last Tetanus booster: _____

YMCA Camp Independence is requiring a COVID 19 Vaccine. This will need to be presented upon check in at Camp. Initial here to confirm your acknowledgement: _____

Please contact camp for an exemption request.

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 should 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

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 _____