

YMCA CAMP JONES GULCH 2012 Health History Form

FORM B

Complete one form per camper. Must be received at camp at least **4 weeks** before camper's arrival.

Camper Name _____ / _____ / _____
Last First Middle Initial Date of Birth Age Gender
 Address _____ City _____ State _____ Zip _____

Parent/Guardian Name _____	Add'l Emergency Contact _____
Relationship _____	Relationship _____
Employed by _____	Employed by _____
Occupation _____	Occupation _____
Phone Home (____) _____ - _____	Phone Home (____) _____ - _____
Work (____) _____ - _____	Work (____) _____ - _____
Cell (____) _____ - _____	Cell (____) _____ - _____

Vaccines

(Approximate Date Immunized)

Diphtheria _____

Measles _____

Tetanus _____

Mumps _____

Pertussis _____

Rubella _____

Chicken Pox _____

Polio _____

Hepatitis B _____

Information Required by State Law

Health Insurance Company _____ Policy Number _____

Dentist _____ Physician _____

Phone (____) _____ - _____ Phone (____) _____ - _____

Medical Information Past or Present

(Check all that apply)

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

*If yes, please complete Form C as well

For each "Yes" please explain:

Dietary Considerations

We can work effectively with most medically prescribed diets but cannot cater to individual food preferences.

Vegetarian Vegan

Other _____

Non-Prescription Medications

I authorize the following medications to be administered as needed:

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

Allergies (Check all that apply)

Penicillin Yes No

Other Drugs Yes No

Foods Yes No

Bee Stings Yes No

Have Bee Sting Kit? Yes No

Other Insects or Animals Yes No

Hay Fever Yes No

Latex Yes No

Any other Allergies? Yes No

For each "Yes" please explain:

Parent/Guardian's Authorization

This health history is correct, so far as I know, and the person herein has permission to engage in all planned camp activities, including out-of-camp trips by bus. In case of accident or illness, I authorize the YMCA to secure emergency medical treatment for this participant and provide my medical insurance provider information. I agree to waive any claims against the YMCA and its members and volunteers for injuries or damages that may result from the conduct of other persons including participants in YMCA programs.

Parent/Guardian's Signature _____ Date _____/_____/_____

Camper Name: Last _____ First _____ Session: _____ Cabin: _____ (for office use)