Health Form Check List

___ Copy of insurance cards (2 sides)
___ Immunization records
___ Current medical history
___ Physician's signature
___ Current Medications

YMCA CAMP FULLER
2009 CAMPER HEALTH HISTORY AND EXAMINATION FORM

* **Immunization History- MANDATORY!** Please provide a written record of the camper's most recent immunizations. Campers may not attend without this record.
* **Please include a copy of all your health insurance cards (medical and dental) with this form**

Name: ____ Birth date: __ __/__ __/__ __ __ __ Gender: M F Age: ___________

Please Circle Session(s) Camper is Attending: FTC1 FTC2 OWS 1 2 3 4 LDI LDII Specialty Camp: ______________

Name of Parent/Guardian: __________________________ Home Phone: _______________ Work/Cell Phone: ________________________

Address: ____
Street City State Zip

If I am not available in an emergency, please notify ____________________________________ (Name) _________________________ (relationship)

Home Phone: ___________________________ Work/Cell Phone:_________________________

Please circle any conditions that your camper has experienced

Frequent Ear Infections
Heart Defect/Disease
Convulsions
Diabetes
Bleeding/Clotting Disorders
Hypertension
Mononucleosis
Psychiatric Treatment

Diseases
Chicken Pox
German Measles
Measles
Mumps

Allergies
Hay fever
Poison Ivy
Poison Oak
Insect Stings
Penicillin
Other Drugs
Asthma

INFORMATION TO BE PROVIDED BY PARENT/GUARDIAN

1. Has the camper required any psychiatric counseling or hospitalization? If yes, please explain
2. Please list any medications your camper is currently taking, including the dose and reason
3. Please list the date and nature of any operations or serious injuries
4. Please describe any disability or chronic or recurring illness
5. Please list any activities encouraged or limited by the physician
6. Please describe any dietary modifications or considerations
7. Does your child have an IEP at school?
8. Females Only: Has the camper begun menstruation? YES NO
   If NO, has she been told about it? YES NO If YES, is menstrual history normal? Please describe
9. Name of Physician ___________________________________ Phone _________________
10. Name of Dentist _____________________________________ Phone _________________

Parent/Guardian Acknowledgment

This health history is correct, as far as I know, and the person herein described has permission to engage in all prescribed camp activities excepted as noted. I hereby give permission to the medical personnel selected by the camp director to order routine tests, x-rays, treatment and necessary transportation for the individual named above. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child named above.

In accordance with Section 7-6-9 of the Rhode Island General Laws "Exemption from Liability to Participants in Sponsored Athletic or Sports Events", I hereby waive any liability against the Greater Providence YMCA, its officers, directors, trustees, agents, servants or employees. They shall not be held liable for any bodily injury incurred while my child is participating in any activity sponsored by YMCA Camp Fuller, except for injury occasioned by an employee's intentional behavior, assault or reckless disregard.

_______________________________________ ____________________
Parent/Guardian Signature Date

Check our website for this form at www.ymcacampfuller.org

Please have your physician fill out the other side

INFORMATION TO BE PROVIDED BY PHYSICIAN

Camper Name: ____

General Health of Camper

Date of Examination ___________________

Height ________ Weight ________ Blood Pressure _______________________________

The camper is under care of a physician for the following condition(s):

____

____

The camper is currently taking the following medications:

____

____

Does the camper have epilepsy? YES NO Does the camper have diabetes? YES NO

Please explain any reported loss of consciousness, convulsions or concussion.

____

____

Are there any medically prescribed meal plans or dietary restrictions? YES NO If yes, please explain.

____

Are there any conditions that would preclude this camper's participation in an active camp program? YES NO
If yes, please explain. ____

____

PHYSICIAN SIGNATURE

I have examined the above-named camper within the past two years. I have found him/her to be in good physical condition and there are no conditions precluding participation in an active camp program except those noted above.

____ ________________________
Signature of Licensed Physician Date

Physician Name____

Address:____
Street City State Zip

Phone: ____

Date of form completion:________________________ by ____