

**YMCA CAMP FULLER
2009 STAFF HEALTH HISTORY AND EXAMINATION FORM**

Health Form Check List

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

* **Immunization History- MANDATORY!** Please provide a written record of the staff's most recent immunizations. Staff may not work 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: _____

Name of Parent/Guardian: _____ Home Phone: _____ Work/Cell Phone: _____

Address: _____
Street City State Zip

Emergency Contact _____ (Name) _____ (relationship)

Home Phone: _____ Work/Cell Phone: _____

INFORMATION TO BE PROVIDED BY PARENT/GUARDIAN

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

1. Have you required any psychiatric counseling or hospitalization? If yes, please explain

2. Please list any medications you are 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. Name of Physician _____ Phone _____
8. Name of Dentist _____ Phone _____
9. Name of Insurance Company _____
 Address _____
Street City State Zip
 Policy # _____ Name of Policy Holder _____

Staff or Parent/Guardian Acknowledgment

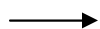
This health history is correct, as far as I know, and the person herein described has permission to engage in all prescribed camp activities excepted as noted. I hereby give permission to the medical personnel selected by the camp director to order routine tests, x-rays, treatment and necessary transportation 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.

Staff or Parent/Guardian Signature if staff is under 18

Date

*if for religious reasons you cannot sign this acknowledgment, please contact the camp or a legal waiver that must be signed prior to attendance.



INFORMATION TO BE PROVIDED BY PHYSICIAN

Staff Name: _____

General Health of Staff

Date of Examination _____

Height _____ Weight _____ Blood Pressure _____

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

The staff member is currently taking the following medications:

Does the staff member have epilepsy? YES NO Does the staff member 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 staff member's participation in an active camp program? YES NO
If yes, please explain. _____

PHYSICIAN SIGNATURE

I have examined the above-named staff member 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 _____