YMCA COLLIN COUNTY ADVENTURE CAMP

Confidential Health Form

This two-page health form is REQUIRED for camp attendance. Pease read carefully and complete in full.

Camper Last Name	First Name	DOB	Age	Gender

Emergency Contact Name			
Home Address		Work Address	
City/State		City/State	
Zip Code		Zip Code	
Phone	( )	Phone	( )

Primary Care Physician		Phone	( )
Dentist		Phone	( )
Insurance Provider		Phone	( )
Policy or Group Number			

Health History (check all that apply):

	Asthma		**Diseases:**		**Allergies:**
	Frequent Ear Infections		Chicken Pox		Hay Fever
	Heart Defect/Disease		Measles		Poison Oak/Ivy, etc.
	Convulsions/Epilepsy		German Measles		Insect Stings
	Diabetes		Mumps		Penicillin
	Bleeding/Clotting Disorders		Mononucleosis		Other Drugs
	Hypertension		Other *(specify below)*		Nuts/Dairy
	Psychiatric Treatment				Other *(specify below)*
	Operations or Serious Injuries				
	Disability/Chronic/Recurring Illness				
	Bed Wetting				

Immunization History (We no longer need a copy of your child's vaccination record.)

Vaccines	Most Recent Dose (MM/YY)	Vaccines	Most Recent Dose (MM/YY)
DPT (Diphtheria, Pertussis, Tetanus)		Hepatitis A	
Tetanus Booster * MM/YY is required		Hepatitis B	
Polio (IPV)		Pneumococcal (PCV)	
MMR (Measles, Mumps, Rubella)		Tuberculin (TB) test	
Meningococcal Meningitis (MCV4)		Varicella (Chicken Pox)	
Haemophilus Influenza Type B (HIB)			

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp director, to order X-rays, routine tests, treatment, and necessary transportation for me/or my child. 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 as named above. The completed forms may be photocopied for trips out of camp.

Parent/Guardian Signature: _____ **Date:** _____

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Confidential Health Form Pg. 2

Camper Name	Height	Weight

Does camper have epilepsy? Y or N Does camper have diabetes? Y or N

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

_____

Any treatment to be continued at camp: _____

_____

Any medically prescribed meal plan or dietary restrictions: _____

_____

Any record of known allergies (food, plants, insects, medication, etc.): _____

_____

If Female, Has camper menstruated? Y or N If so, is her menstrual history normal? Y or N

_____

Any medications to be administered while at camp:_____

Please fill out Parent Authorization Medicine form.

Any activities encouraged or limited at camp: _____

_____

Additional health information: _____

_____

_____

_____

PARENT AUTHORIZATION FOR MEDICATION FORM

*one form is required for each medication

Name of Child: _____ Date of Birth: _____ Weight: _____

Medication Type: Prescription Medication Non-Prescription Medication

Medication: _____ Prescription #: _____ Dosage: _____

Time(s) of Day Medication is to be Given: Lunch Dinner Other: _____

When was last dose given to child: _____

Reason for Medication: _____

Special Instructions: _____

Possible Side Effects: _____

Continue Medication Until (date): _____

Doctor Name _____ Doctor's phone # _____

Parent's Primary Phone _____ Parent's Secondary Phone _____

I GIVE PERMISSION FOR YMCA OF METROPOLITAN DALLAS TO ADMINISTER THE ABOVE REFERENCED MEDICATION ACCORDING TO THE INSTRUCTIONS ABOVE TO MY CHILD, _____ WHILE IN THE CARE OF THE YMCA, AS ORDERED BY MY HEALTHCARE PROVIDER.

Parent/Guardian Name: _____ Signature: _____ Date: _____

*****This Section Completed by YMCA Health Officer*****

Prescription Medication	**Non-Prescription Medication**
Parent Permission Received (this form)	Parent Permission Received (this form)
Original prescription label is readable	Original manufacturer label is readable
Name and strength of medication on label	Name and strength of medication on label
Medication is not expired	Medication is not expired
Name of child matches intended recipient	Storage instructions
Health care provider name/contact on container	Health care provider written note is provided
Dispense instructions	Dispense instructions
Storage instructions	Child medication log set up
Child medication log set up	
_____	_____
Health Officer Signature	Health Officer Signature

*****This Section Completed by YMCA Health Officer*****

Returned to Child's Parent/Guardian Thrown Away Date: _____

_____ _____