

For Office Use

# Health History and Examination Form for Children, Youth and Adults Attending Camps



**MAIL TO:**  
**SUSSEX COUNTY YMCA**  
 15 WITS END ROAD  
 HAMBURG, NJ 07419  
 Tel: 973-209-9622

Year

We build strong kids, strong families, strong communities

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. This form, except for the "Health Recommendations of Licensed Medical Personnel," to be filled in by parents/guardians of minors or by adults themselves.

Camper Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_  
Last First Middle

Home address \_\_\_\_\_  
Street address City State Zip

Social security number of participant \_\_\_\_\_ Gender:  Male  Female

Custodial parent/guardian \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Home address \_\_\_\_\_  
(if different from above) Street address City State Zip

Business address \_\_\_\_\_ Phone \_\_\_\_\_  
Street address City State Zip

Second parent or guardian or emergency contact \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street address City State Zip

Business address \_\_\_\_\_ Phone \_\_\_\_\_

If not available in an emergency, notify:

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street address City State Zip

### Important-These boxes must be completed for attendance\*

#### Permission to Provide Necessary Treatment or Emergency Care:

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related 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 the person named above. This completed form may be photocopied for trips out of camp.\*

Signature of parent or guardian or adult camper/staffer \_\_\_\_\_

I also understand and agree to abide by the restrictions placed on my camp activities.

Signature of minor or adult camper/staffer \_\_\_\_\_ Date \_\_\_\_\_

*\*If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

#### Insurance Information

Is the participant covered by family medical/hospital insurance?  Yes  No Prescription Plan  Yes  No

If so, indicate carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

Carrier address \_\_\_\_\_

Name of insured \_\_\_\_\_ Relationship to participant \_\_\_\_\_

Social security number of policy holder or insurance ID number \_\_\_\_\_

Prescription Plan Name \_\_\_\_\_ Telephone \_\_\_\_\_

Cabin or Group

Name

# Health History

The following information must be filled in 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** List all known. Describe reaction and management of the reaction

### Medication allergies (list)

_____	_____
_____	_____
_____	_____

### Food allergies (list)

_____	_____
_____	_____
_____	_____

**Other allergies (list)** — include insect stings, hay fever, asthma, animal dander, etc.

_____	_____
_____	_____
_____	_____

## MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original

packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

<input type="checkbox"/> This person takes NO medications on a routine basis.
<input type="checkbox"/> This person takes medications as follows: Med #1 _____ Dosage _____ Specific times taken each day _____ Reason for taking _____ Med #2 _____ Dosage _____ Specific times taken each day _____ Reason for taking _____ Med #3 _____ Dosage _____ Specific times taken each day _____ Reason for taking _____ Attach additional pages for more medications. Identify any medications taken during the school year that participant does/may not take during the summer: _____ _____

## RESTRICTIONS

The following restrictions apply to this individual.

### Dietary

- Does not eat red meat
- Does not eat pork
- Does not eat eggs
- Does not eat poultry
- Does not eat seafood
- Does not eat dairy products
- Other (describe) \_\_\_\_\_

**Explain any restrictions to activity** (e.g. what cannot be done, what adaptations or limitations are necessary)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**General Questions** (Explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			
16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions.

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Which of the following has the participant had?

- Measles
- Chicken pox
- German measles
- Mumps
- Hepatitis

TB Mantoux Test

Date of last test \_\_\_\_\_

Result:  Positive  Negative

Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
or Measles		_____	_____	_____	_____	_____	_____
or Mumps		_____	_____	_____	_____	_____	_____
or Rubella		_____	_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____	_____	_____
BCG		_____	_____	_____	_____	_____	_____

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.

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Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**Parent/Guardian Authorizations:** This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted

Signed \_\_\_\_\_ Printed \_\_\_\_\_ Date \_\_\_\_\_

**Health Care Recommendations by Licensed Medical Personnel**

I have examined the above camp participant Date of last examination \_\_\_\_\_

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant  is  is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions

\_\_\_\_\_  
\_\_\_\_\_

Current treatment at the time of this report includes

\_\_\_\_\_  
\_\_\_\_\_

**Recommendations and Restrictions at Camp**

Treatment to be continued at camp

\_\_\_\_\_  
\_\_\_\_\_

Medications to be administered at camp (name, dosage, frequency)

\_\_\_\_\_  
\_\_\_\_\_

Any medically-prescribed meal plan or dietary restrictions

\_\_\_\_\_  
\_\_\_\_\_

Known allergies

\_\_\_\_\_  
\_\_\_\_\_

Description of any limitation or restriction on camp activities

\_\_\_\_\_  
\_\_\_\_\_

Additional information for health care staff at the camp

\_\_\_\_\_  
\_\_\_\_\_

**Signature of Licensed Medical Personnel** \_\_\_\_\_

Printed \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_

*For camp use only*

**Screening Record**

Date screened \_\_\_\_\_ Time \_\_\_\_\_ am  
pm

Meds received \_\_\_\_\_

Updates/additions to health history noted  Yes  No  None required

Current health needs identified \_\_\_\_\_

Observational notes \_\_\_\_\_

Screened by \_\_\_\_\_