YMCA Camp Independence

2025 Health History and Examination Form

The information on this form is gathered to assist us in identifying appropriate care. Health history must be filled out by parents/guardians of minors or by adults. Update required annually. A licensed medical personnel must complete the health exam on the (back page). **NOTE: Please make a copy of this form for your records before sending the original to camp.**

Camper Name ____ Birth date __________________ Age at camp _________

Home address ____
Street Address City State Zip

Gender: ❑ Female ❑ Male Height _______________ Weight ____________ Nickname _______________________

Custodial parent/guardian ____ Phone ________________________

Home address ____ Cell _______________________
If different than above Street Address City State Zip

Business address____ Phone ____________________
Street Address City State Zip

Second parent/guardian ____

Home address ____ Cell _______________________
If different than above Street Address City State Zip

Business address____ Phone ____________________
Street Address City State Zip

If there is an emergency at camp, please list who to notify in number order.

#1 Name ____ Relationship ___________________________________

Home Phone ___________________________ Cell Phone _______________________ Other Phone ___________________________

#2 Name ____ Relationship___________________________________

Home Phone ___________________________ Cell Phone _______________________ Other Phone ___________________________

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? ❑ Yes ❑ No
If so, indicate carrier or plan name ____________________________________ Group # ______________________________

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

It is my intention that the camp staff be treated as acting *in loco parentis* for the person herein named as a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for camp purposes.

Signature of parent or guardian or adult camper____

Printed Name ____ Date ____________________________

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper ____ Date __________________________________

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

Health History

The following information must be filled out 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:
❑ **Penicillin** ❑ **Latex** If so, what type of a reaction does your camper have? __ Anaphylactic __hives __rash
List all other allergies:

_________________________ ____

_________________________ ____

_________________________ ____

Is your camper allergic to bee stings? ❑ **Yes** ❑ **No** If so, what is the camper's reaction when stung? __________

____

FOOD ALLERGIES: List all known

_________________________ ____

_________________________ ____

_________________________ ____

_________________________ ____

MENTAL: ❑ Attention Deficit Disorder ❑ Memory Problems ❑ Emotional Problems
❑ Fears (list below) ❑ Learning Difficulties (list below)

____

____

BEHAVIORAL: ❑ Likes to be the center of attention ❑ Does not acclimate well in groups ❑ Depression
❑ May be stubborn ❑ May be aggressive when upset ❑ Other (list below)

____

____

Has your camper been diagnosed with any behavior disorders? ❑ **Yes** ❑ **No** If so, please explain. __________

____

PHYSICAL: ❑ Hydrocephalus ❑ Speech Problems ❑ Does camper have a shunt?
❑ Seizures(specify type below) ❑ Fine Motor Skills ___ Yes ___ No Type: ____________
❑ Other (list below)
Last revision (date) _________________
Neurosurgeon ____________________
Phone ____________________________

If camper has a shunt, is the shunt programmable? __ Yes __ No If yes, what is the valve set at? ______

____

____

Gastrointestinal: ❑ Constipation ❑ Feeding problems ❑ Abnormal Stools ❑ Acid Reflux
❑ Impaction ❑ Diarrhea ❑ Polyps ❑ Tube Feeding
❑ Diverticulitis ❑ Other (list below)

____

____

Respiratory: ❑ Sleep Apnea ❑ Wheezing ❑ Shortness of breath
❑ Asthma ❑ Nebulizer Treatments (how often? ________)
❑ Other (list below)

____

____

Muscular/Skeletal: ❑ Bones break easily ❑ Scoliosis ❑ Kyphosis
❑ Muscle weakness ❑ Lordosis ❑ Other (list below)

____

____

Skin : ❑ Rash ❑ Pressure sores (__ Reddened __ Open area __ Drainage)
❑ Ulcers ❑ Cuts or scrapes
❑ Other (list below) ❑ Insect bites

Is camper currently being treated for any skin breakdown? ____

____

____

Mobility: Camper uses ❑ Wheelchair (__ manual __ electric) ❑ Walker ❑ Crutches ❑ Leg Braces
❑ AFO's ❑ Transfers (__ unassisted __ with assisted-explain below)
❑ Other (list below) ❑ Prosthesis/cast/orthotics

____

____

Bladder Management: ❑ Toilet Trained Is camper on a bladder program? __ Yes __ No
❑ Briefs/Panties If yes, size of catheter _____________
❑ Disposable Undies Catheter schedule __________________________
❑ Pullups ❑ Self Cath ❑Assist Cath ❑ Nurse Cath
❑ Diapers ❑ Needs Assistance (Describe below)
❑ Incontinent pads ❑ Other (list below)

____

____

BOWEL MANAGEMENT: Is the camper on a bowel program? ____ Yes ____ No If yes, explain _____

____

❑ Mace How long does the camper sit on the toilet? _____________ ❑ Unassisted ❑ Assisted
❑ Digital Stimulation ❑ Suppositories ❑ Laxatives
❑ Cone enema (amount of water _________ How long? __________) ❑ Other (specify below)

____

PERSONAL CARE: How much of his/her own care can camper perform?________________________________

❑ Independent Care ❑ Needs Assistance (Describe below)

❑ Females: Date of last menstrual cycle _______________________________________
❑ Irregular cycle ❑ Normal cycle ❑ Pads ❑ Tampons

____

____

OTHER SPECIAL TREATMENTS:

____

____

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

❑ Does not eat red meat ❑ Does not eat pork ❑ Does not eat eggs ❑ Gluten free
❑ Does not eat poultry ❑ Does not eat seafood ❑ Does not eat dairy products ❑ No peanuts
❑ Other (describe) ____

Explain any restrictions with activities ____

____

____

Which of the following has the participant had?

❑ Measles ❑ Chicken Pox ❑ German measles ❑ Mononucleosis
❑ Mumps ❑ Hepatitis A ❑ Hepatitis B ❑ Hepatitis C

All immunizations required for school are up to date. ____ YES ____ NO (exemption letter must accompanying this form.

Date of last Tetanus booster: ________________________

YMCA Camp Independence is requiring ALL forms to be completed and sent in no later than 3 weeks prior to your camper's session starting. Please Initial here:

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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____
____
____
____

Can participant swim? ❑ Strong swimmer ❑ Needs Assistance ❑ Non swimmer ❑ Wears lifejacket or needs floaters

Name of Family Physician:____ Phone ________________________________
Address ____

Name of dentist/orthodontist:____ Phone ____________________________
Address ____

MEDICATION INFORMATION

Please list all medications that the participant takes routinely, this includes over-the-counter, non-prescription or prescription drugs. Be sure to bring enough medication to last the entire time the participant is at camp. Allow for spillage by sending an extra couple doses. **Medications must be in their original packaging or bottles that identify the prescribing physician, the name of the medication, the dosage and the frequency of administration.** The original containers will be returned at the end of the camp session.

Name of Medication Example: Oxybutinin	**Strength** 5 mgm	**Frequency** 1 tab, 3 times a day	**Special Instructions** Crush tab and take with juice

The information provided on this form is true and correct to the best of my knowledge.

Parent/Guardian/ Self Signature ____ Date ____________________

Printed Name: ____

CAMP INDEPENDENCE MEDICAL FORM
Must be signed by a Physician

Parents are not to fill out the form for the Physician to sign; medical staff must fill out form.

Physician's Statement: I have examined ______________________________ and find him/her physically able to attend camp. I understand that the treatment plan will be followed at camp, unless other orders are received.

BP _________________________ Weight ___________________________ Height __________________________

Physical Exam

General Appearance: ____

Lungs____

Abdomen____

Neurological____

Skin____

Heart____

Extremities____

Physical Exam significant findings/limitations:

____

____

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Please describe any current medical problems:

____

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____

Additional information for health care team staff at the camp:

____

____

____

Treatment to be continued at the camp:

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____

Signature of Physician ____ Date of exam ___________________

Printed Name: ___________________________________ Phone ____________________________________

Address ____

Signature of Reviewing Advising Physician ____ *Date*______________