Camper Name:
Session:
Gender:
DOB:
Age at camp:
U/V, Cabin:
Allergies:
Health Check In:
Health Check Out:

BCCYMCA HEALTH FORM

Camper Name:

Address:_____ _____

Number Street City State Zip

Country

	Parent/Guardian 1	Parent/Guardian 2	Alternate Contact 1
Full Name			
Relationship to Camper			
Primary Phone			
Alternate Phone			
Email			

If Parents are Separated, who has Legal Custody? Physical Custody?

Insurance Information:

Insurance Company :

Insurance Company Phone Number:

Subscriber:

Medical Insurance Policy No

Group No.

Parent/Guardian authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician and/or licensed medical staff.

I give permission to the physician and/or licensed medical staff selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. I understand that routine care of my child at camp may include the administration of over the counter medications including aspirin, acetaminophen, ibuprofen, diphenhydramine, and other medication that will be administered as needed unless I have provided explicit instructions for a particular medication to not be administered. In addition, I understand that preventatives such as hand sanitizer, sunscreen and bug repellent, including DEET-based repellent may be administered by camp staff to participants unless I have given explicit instructions indicating that sunscreen and/or bug repellent may not be administered to my child.

I understand that my child is responsible for self-care including regular bathing, brushing of teeth, applying their own sunscreen and bug repellent as well as checking for ticks on regular basis and alerting staff members of health concerns.

If I cannot be reached in an emergency, I give my permission to the physician and/or licensed medical staff to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child.

I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

_____ _____

Signature Date

Health-Care Providers:

Date of Last Physical Exam: (Must be within 1 year of attending camp):

Name of and phone number of primary doctor(s):

Food Allergies: ☐ **Yes** ☐ **No** Please list food allergies and the date and nature of the last reaction:

Other Allergies: ☐ **Yes** ☐ **No** Please list other allergies and the date and nature of the last reaction:

Dietary Restrictions: ☐ **Yes** ☐ **No** Does your child have any Dietary Restrictions? Please list the restrictions (vegetarian, gluten free, etc.) as well as the basis of the restrictions (i.e. Medical, Religious, Personal Choice)

Restricted Activities: ☐ **Yes** ☐ **No**

Please tell us about any camp activities that the camper cannot participate in as well as the basis of the restriction.

MEDICATIONS BEING TAKEN **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.**

Will this camper be taking any medications while attending camp: ☐ **Yes** ☐ **No**

Please list all medications and supplements including the dosage and frequency of administration.

Will this camper be bringing an EPI pen to camp? ☐ **Yes** ☐ **No** Does your child keep an EPI pen at home? ☐ **Yes** ☐ **No**

Will this camper be bringing a rescue inhaler to camp? ☐ **Yes** ☐ **No**

General Questions (Explain "yes" answers below.) Has/does the participant:

Had any recent injury or illness?	☐ Yes	☐ No	Ever had problems with back or joints?	☐ Yes	☐ No
Have a recent infectious disease?	☐ Yes	☐ No	Have any skin problems (e.g., rash, acne)?	☐ Yes	☐ No
Have a chronic or recurring illness?	☐ Yes	☐ No	Wear glasses, contacts or protective eye wear?	☐ Yes	☐ No
Ever been hospitalized?	☐ Yes	☐ No	Have asthma, wheezing or shortness of breath?	☐ Yes	☐ No
Ever had surgery?	☐ Yes	☐ No	Had mononucleosis in the past 12 months?	☐ Yes	☐ No
Have frequent headaches?	☐ Yes	☐ No	Had problems with diarrhea/constipation?	☐ Yes	☐ No
Have diabetes?	☐ Yes	☐ No	Have problems with sleepwalking?	☐ Yes	☐ No
Have a history of bed-wetting?	☐ Yes	☐ No	If female, have an abnormal menstrual history?	☐ Yes	☐ No
Had fainting or dizziness?	☐ Yes	☐ No	Ever passed out/ had chest pain during exercise?	☐ Yes	☐ No
Ever had seizures?	☐ Yes	☐ No	Has special services at school?	☐ Yes	☐ No
Is your child currently being treated or have ever been treated for any cognitive, physical or behavioral issues?				☐ Yes	☐ No
Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others				☐ Yes	☐ No

Please explain "Yes" answers in the space below. The camp may contact you for additional information.

What Have We Forgotten to Ask? Do you have more to tell us? (i.e., allergy plan, additional explanation).

I will be sending another letter for the nurses/ counselors to explain more ☐ **Yes** ☐ **No**

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