

YMCA Camp Cullen

Health History and Examination Form

The information on this form is not part of the camper 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 campers.

Session Attending: _____

Must mail 3 weeks prior to the session attending to:
YMCA Camp Cullen
460 Cullen Loop, Ste. A
Trinity, Tx 75862
(936) 594-2274 Fax (936) 594-3237

Name _____ Birth date _____ Age at Camp _____
Last First Middle

Home Address _____
Street Address City State Zip

Social security number of camper _____ Gender Male Female

Custodial parent/guardian _____

Phone _____ Business Phone _____

Address _____
Street Address City State Zip

Second Parent or guardian or emergency contact _____

Phone _____ Business Phone _____

Address _____
Street Address City State Zip

Business Address _____
Street Address City State Zip

If not available in an emergency, notify: Name _____

Relationship _____ Phone _____

Address _____
Street Address City State Zip

Insurance Information (Copy of insurance cards are required)

Is the participant covered by family medical/hospital insurance? 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 _____

You must provide a copy of the insurance card!

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. 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.

Signature of parent or guardian of camper _____
 _____ Initials**** Upon initialing you are authorizing this form with an electronic signature.

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

Signature of camper _____ Date _____

Year _____
Session _____
Name _____

Health History **Camper Name** _____ **M** ___ **F** ___

The following information must be filled in by the parent/guardian. 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 the 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 non-prescription 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 otherwise we are unable to dispense medication**, (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. All prescriptions must be signed by a physician (see Licensed Medical Personnel recommendations on the last page).

This person takes NO medications on a routine basis.

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)

Session Attending: _____

Camper Name _____ M ___ F ___

General Questions (Explain "yes" answers below.)

Has/does the participant:	Y	N	Has/does the participant:	Y	N
1. Had any recent injury, illness or infectious disease			16. Ever had back problems		
2. Have a chronic or recurring illness/condition			17. Ever had problems with joints (e.g. knees, ankles)		
3. Ever been hospitalized			18. Have an orthodontic appliance being brought to camp		
4. Ever had surgery			19. Have any skin problems (e.g. itching, rash)		
5. Have frequent headaches			20. Have diabetes		
6. Ever had a head injury			21. Have asthma		
7. Ever been knocked unconscious			22. Had mononucleosis in the past 12 months		
8. Wear glasses, contacts or protective eye wear			23. Had problems with diarrhea/constipation		
9. Ever had frequent ear infections			24. Had problems with sleepwalking		
10. Ever passed out during or after exercise			25. Ever had an eating disorder		
11. Ever been dizzy during or after exercise			26. Have a history of bed-wetting		
12. Ever had seizures			For Female		
13. Ever had chest pain during or after exercise			27. Has this person menstruated		
14. Ever had high blood pressure			28. If so, is her menstrual history normal		
15. Ever been diagnosed with a heart murmur			29. If not, has she been told about it		

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

Which of the following has the participant ever had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis

TB Test

Date of last test _____

Result: Positive Negative

Family Physician _____

Business Phone _____

Address _____
Street Address City State Zip

Family dentist/orthodontist _____

Business Phone _____

Address _____
Street Address City State Zip

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 _____

Session Attending: _____

Camper Name _____ M ___ F ___

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 _____

Business Phone _____ Date _____

Address _____

**RETURN SIGNED FORM TO: YMCA Camp Cullen
409 Cullen Loop, Ste. A – Trinity, TX
936-594-2274 / Fax 936-594-3237**

For camp use only

Screening Record

Date screened _____ Time _____ (am/pm)

Meds received _____

Updates/additional to health history noted: _ Yes _ No _ None Required

Current health needs identified _____

Observational Notes _____

Screened by _____