



FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

**DO NOT MAIL**  
**PLEASE BRING FORM TO**  
**CAMP ON CHECK-IN DAY**

# YMCA CAMPER HEALTH HISTORY FORM

Camper Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_  
(Last) (First)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
Home

Parent/Guardian 1 Name: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Parent/Guardian 2 Name: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Family Email Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

**Immunization History** Are all immunizations up to date?  Yes  No Date of last tetanus shot (if known): \_\_\_\_/\_\_\_\_/\_\_\_\_

**Medical Information**

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of last physical exam: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Medical Insurance Carrier: \_\_\_\_\_ Policy and/or group #: \_\_\_\_\_

**Past or Present (please check). If YES for asterisk \* items, must have a Doctor's Authorization completed (reverse side)**

Currently under Dr. care* <input type="checkbox"/> Yes <input type="checkbox"/> No	ADD/ADHD <input type="checkbox"/> Yes <input type="checkbox"/> No	Head Lice (recent) <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart defect/disease* <input type="checkbox"/> Yes <input type="checkbox"/> No	Autism <input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No
Recent hospitalization* <input type="checkbox"/> Yes <input type="checkbox"/> No	Asperger's Syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No	Measles <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma* <input type="checkbox"/> Yes <input type="checkbox"/> No	Bedwetting <input type="checkbox"/> Yes <input type="checkbox"/> No	German Measles <input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures* <input type="checkbox"/> Yes <input type="checkbox"/> No	Sleepwalking <input type="checkbox"/> Yes <input type="checkbox"/> No	Other diseases/conditions <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes* <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No	

For each  Yes, please explain: \_\_\_\_\_

<b>Allergies:</b> Bee Stings <input type="checkbox"/> Yes <input type="checkbox"/> No require epipen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Food Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No List _____	Rhino Oak/Ivy <input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No
Other insect/animals <input type="checkbox"/> Yes <input type="checkbox"/> No List _____	Any airborne allergies <input type="checkbox"/> Yes <input type="checkbox"/> No List _____	Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No List _____

**Dietary Restrictions?**  Yes  No \_\_\_\_\_

Any reason to restrict full activity including swimming, long hikes, strenuous physical games?  Yes  No

Any current mental, or psychological conditions requiring special consideration or restrictions?  Yes  No

For each  Yes, please explain: \_\_\_\_\_

**Current medications:** to be continued at camp: *(use additional pages if necessary)*

Med Name, Dosage \_\_\_\_\_ (Circle frequency) Breakfast, Lunch, Dinner, Bedtime, As needed, Other time \_\_\_\_\_

Med Name, Dosage \_\_\_\_\_ (Circle frequency) Breakfast, Lunch, Dinner, Bedtime, As needed, Other time \_\_\_\_\_

Med Name, Dosage \_\_\_\_\_ (Circle frequency) Breakfast, Lunch, Dinner, Bedtime, As needed, Other time \_\_\_\_\_

**Inhalers or Epipens** brought to camp? List what for and instructions \_\_\_\_\_

Other Medication Instructions for Health Care Staff: \_\_\_\_\_

**Non-Prescription Medications** I authorize the following medications or generic equivalent to be administered as needed:

Cough/Sore throat (Robitussin) <input type="checkbox"/> Yes <input type="checkbox"/> No	Metamucil <input type="checkbox"/> Yes <input type="checkbox"/> No	Pepto Bismol <input type="checkbox"/> Yes <input type="checkbox"/> No	Cough Syrup <input type="checkbox"/> Yes <input type="checkbox"/> No
Acetaminophen (Tylenol) <input type="checkbox"/> Yes <input type="checkbox"/> No	Benadryl <input type="checkbox"/> Yes <input type="checkbox"/> No	Ibuprofen (Advil) <input type="checkbox"/> Yes <input type="checkbox"/> No	Hydrocortisone <input type="checkbox"/> Yes <input type="checkbox"/> No

**Ethnicity** (for statistical reporting only)  Black/African American  Asian/Pacific Islander  Hispanic/Latino  
 White/Caucasian  Native American  Other: \_\_\_\_\_

**Waiver of Liability:** I, the undersigned parent/person having legal custody/guardianship of the above said minor, give permission for the minor to participate in the YMCA program described above. The minor is physically able and mentally prepared to participate in all activities as described in the announcement for the program. In consideration of said minor being permitted to enter any branch of YMCA of San Diego County ("YMCA") for observation, use of facilities and/or equipment, or participation of the above or any program, I, on behalf of myself (as parent, guardian, coach, aide, spectator or participant) hereby: 1. Acknowledge that (i) I have read this document, (ii) I have had the opportunity to inspect the YMCA facilities and equipment, (iii) I accept them as being safe and reasonably suited for the purposes intended and (iv) I voluntarily sign this document. 2. Release YMCA, its directors, officers, employees and volunteers (collectively "Releasees") from all liability to me for any loss or damage to property or injury or death to person, whether caused by Releasees or otherwise and while such minor is in or near any YMCA branch. 3. I agree not to sue Releasees for any loss, damage, injury or death described above and I will indemnify and hold harmless Releasees and each of them from any loss, liability, damage or cost they may incur due to said minor's presence in, upon or near the YMCA branch; whether caused by the negligence of Releasees. 4. I assume full responsibility for, and risk of, bodily injury, death or property damage due to the negligence of Releasees or otherwise. 5. I do hereby authorize the YMCA as agent for the undersigned, to consent with respect to said minor, to any x-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under general or special supervision of, any physician and surgeon licensed under the provisions of the California Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of the physician or at the hospital. I understand that the YMCA is not responsible for costs incurred for medical care. I intend this document to be as broad and inclusive as is permitted by the laws of the State of California; if any portion hereof is held invalid, I agree the balance shall continue in full force and effect.

**Luggage Search:** I agree that any camp participant's belongings may be searched outside the participant's presence for drugs, alcohol, weapons or other forbidden objects.

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Photographic Waiver/Consent:** I give permission to the YMCA of San Diego County to use my picture or other likeness, or a picture or other likeness of any of my children in the YMCA's general publicity and campaign materials.

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_



**THIS SECTION TO BE COMPLETED IF CURRENTLY UNDER DOCTOR'S CARE OR \*ASTERISK-HEALTH CONDITION IS CHECKED ON FRONT OF THIS FORM.**

**Note:** A Doctor's written authorization is only required if the camper has a history of Asthma, Heart Defect/Disease, Seizures, Diabetes, has been recently hospitalized, or is currently under a Doctor's care. If so, complete this section.

**Health Examination by Licensed Physician**

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_\_\_

Parent's name: \_\_\_\_\_

Because of this camper's medical history, we have asked that your written authorization be provided prior to their attendance at YMCA Camp. Please realize that camp is held at either mountain (4300 feet elevation) or oceanfront settings. The programs are very active with strenuous hiking, games, swimming, and camp activities. Your careful consideration is appreciated.

I have examined the child named on this form within the past two years. Date examined: \_\_\_/\_\_\_/\_\_\_

After examination and my review of his/her health history, it is my opinion that this person is physically able to engage in camp activities, except as noted below.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood pressure: \_\_\_\_\_

Is the applicant under the care of a physician for any conditions?  Yes  No Please explain \_\_\_\_\_

Any specific activities to be encouraged or limited by physician's advice? \_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions? \_\_\_\_\_

Any treatment or medications to be continued at camp (please give specific dosages)? \_\_\_\_\_

Any allergies? (Food, drugs, plants, insects, etc) \_\_\_\_\_

Additional health information: \_\_\_\_\_

Licensed physician signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of form completion: \_\_\_/\_\_\_/\_\_\_ By: \_\_\_\_\_

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