

YMCA Camp Hanes Health History 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: _____

Mail to Camp Hanes 30 days prior to the Session

YMCA Camp Hanes

1225 Camp Hanes Rd.

King, NC 27021

P 336 983 3131 F 336 983 4624

Camper's Name _____ Birth date _____ Age at Camp _____

Gender: Male Female Race: _____

Custodial Parent/Guardian _____ Phone _____ Business/Cell Phone _____

Address _____
Street Address City State Zip

Second Parent or Guardian: _____ Phone _____ Business/Cell Phone _____

Address _____
Street Address City State Zip

Other Emergency Contact: Name _____ Relationship _____

Phone _____ Business/Cell Phone _____

Family Physician: _____ Business Phone _____

Address _____
Street Address City State Zip

Family Dentist/Orthodontist: _____ Business Phone _____

Address _____

Health Care Recommendations by Licensed Medical Personnel: Date of last examination: _____

I have examined the above camp participant. In my opinion, the above is or is not able to participate in an active camp program.

Signature of Licensed Medical Personnel _____ Printed Name _____

Title _____ Business Phone _____ Date _____

Insurance Information: 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 _____

Important — The following 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 _____ Date _____

Witness _____ Date _____

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

Signature of camper _____ Date _____

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

Health History

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. Please provide complete information.

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

List Medications your child is taking at this time. _____

Allergies: List all known. Medication allergies: _____

Food allergies: _____

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

Which of the following has the participant ever had?

- Measles Chicken Pox
 German Measles Mumps
 Hepatitis
 TB Mantoux Test Date _____
 Result: Positive Negative

Please give all dates of immunization:

Vaccine:	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	___					

General Questions please explain any “yes” answers

Has/does the participant:		Y	N	Has/does the participant:		Y	N
1.	Have a chronic or recurring illness/condition?			12.	Ever had problems with joints (e.g. knees, ankles)?		
2.	Have frequent headaches?			13.	Have diabetes?		
3.	Ever had a head injury?			14.	Have any skin problems (e.g. itching, rash)?		
4.	Ever been knocked unconscious?			15.	Have asthma?		
5.	Ever had high blood pressure?			16.	Had mononucleosis in the past 12 months?		
6.	Ever had frequent ear infections?			17.	Will your child need any prescription medications at camp?		
7.	Ever had seizures?			18.	Ever had an eating disorder?		
8.	Ever had chest pain during or after exercise?			For Female:			
9.	Ever had back problems?			19.	Has this person menstruated?		
10.	Had any recent injury, illness or infectious disease?			20.	If so, is her menstrual history normal?		
11.	Had any recent surgery?			21.	If not, has she been told about it?		

Please explain any “yes” answers, noting the number of the question (above).
