FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Session # _____

YMCA CAMP SILVER BEACH

HEALTH HISTORY & EXAMINATION FORM

- **Return originals by May 15 (or immediately, for late registrations) to YMCA Camp Silver Beach, PO Box 69, Jamesville, VA 23398 or scan and email to info@campsilverbeach.org.**
- Every camper must have a physical exam within **12 MONTHS** of his or her time at camp
- A new health form must be submitted each year.
- **Pages 1–3 are to be filled out by the parent; page 4 must be filled out by the medical professional**
- Please keep a copy for your records.

Camper Name _____ Gender **M F** Birthdate _____
Last First Middle/Nickname MM/DD/YY

Home Address _____
Street Address City State Zip

We use this information to:
- Brief kitchen staff about dietary restrictions
- Educate counseling staff about camper needs
- Provide healthcare staff with pertinent information

Receiving adequate information prior to your child's arrival is crucial to our ability to provide a supportive environment.

ALLERGIES: ☐ No known allergies ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
(Please describe below what the camper is allergic to, and the reaction seen)

DIET: ☐ This camper eats a regular diet. ☐ This camper has food allergies listed above. ☐ This camper has special food needs.
(Please describe below.)

RESTRICTIONS: ☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. (Please describe below.)

Camper is: ☐ Excited ☐ Nervous ☐ Caring ☐ Trusting ☐ Enthusiastic ☐ Energetic ☐ Shy ☐ Responsible ☐ Positive ☐ First time camper
select all that apply:

Special considerations:
We use this information to help your Camper have a positive experience.
(Please describe below.)

☐ Experiences Bed Wetting ☐ Has struggled with homesickness ☐ Has been dealing with bullying
☐ Special Needs ☐ Is away from home for the first time ☐ Has a major life event
☐ Autism ☐ ADD/ADHD ☐ Behavior/emotional concerns
☐ Eating disorder

WHAT HAVE WE FORGOTTEN TO ASK?

Please provide in the space below any additional information about the camper's health that you think is important or that may affect the camper's ability to fully participate in the camp program. (Attach additional information if needed.)

_____

_____

_____

PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE

This health history is correct and accurately reflects the individual's health status. This individual has permission to participate in all camp activities except as noted. I give permission to the physician 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 agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. If I cannot be reached in an emergency, I give my permission to the physician selected by the camp to secure and administer treatment, including hospitalization, of the person named above. I understand the information on this form may be shared with appropriate camp staff as needed. This completed form may be photocopied for trips out of camp.

Printed Name: _____ Date: _____

Signature of parent/guardian or adult camper/staffer: _____

Camper Name _____ Gender **M F** Birthdate _____
Last First Middle/Nickname MM/DD/YY

MEDICATIONS

If your child takes prescription medication, please note the following:

- Bring enough medication to last his or her entire time at camp
- Keep all medication in the original packaging/bottle with prescription label identifying the prescribing physician, name of medication, dosage and frequency of administration.

☐ This camper takes NO medication on a regular basis. ☐ This camper takes medication as follows:

Name of Medication	Reason for Taking	When it is Given	Amount or Dose to be Given
		☐ Breakfast ☐ Bedtime ☐ Lunch ☐ Other ☐ Dinner	
		☐ Breakfast ☐ Bedtime ☐ Lunch ☐ Other ☐ Dinner	
		☐ Breakfast ☐ Bedtime ☐ Lunch ☐ Other ☐ Dinner	
		☐ Breakfast ☐ Bedtime ☐ Lunch ☐ Other ☐ Dinner	

The list of over-the-counter medication (OTC) stocked in the camp Health Center for administration on an as-needed basis includes but is not limited to:

Acetaminophen (Tylenol) Ibuprofen (Advil/Motrin) Imodium AD Calamine Lotion Dextromethorphan cough syrup (Robitussin DM)
Sore Throat Spray Tums Loratadine (Claritin) Antibiotic Ointment Sudafed Cortisone Cream
Diphenhydramine antihistamine (Benadryl) Cough Drops

Cross out the OTC medicines that the camper should NOT be given and list any others to be avoided: _____

GENERAL HEALTH HISTORY

Check "Yes" or "No" for each statement. Explain "Yes" answers below. Has/Does the camper:

1.	Ever been hospitalized?	☐ Yes ☐ No	11.	Had fainting or dizziness?	☐ Yes ☐ No
2.	Ever had surgery?	☐ Yes ☐ No	12.	Passed out/had chest pain during exercise?	☐ Yes ☐ No
3.	Had asthma/wheezing/shortness of breath?	☐ Yes ☐ No	13.	Had mononucleosis ("mono") during the past 12 months?	☐ Yes ☐ No
4.	Had a recent infectious disease?	☐ Yes ☐ No	14.	If female, have problems with periods/menstruation?	☐ Yes ☐ No
5.	Had a recent injury?	☐ Yes ☐ No	15.	Have problems with falling asleep/sleep walking?	☐ Yes ☐ No
6.	Have recurrent/chronic illnesses?	☐ Yes ☐ No	16.	Ever had back/joint problems?	☐ Yes ☐ No
7.	Have diabetes?	☐ Yes ☐ No	17.	Have a history of bedwetting?	☐ Yes ☐ No
8.	Had seizures?	☐ Yes ☐ No	18.	Have problems with diarrhea/constipation?	☐ Yes ☐ No
9.	Had headaches?	☐ Yes ☐ No	19.	Have any skin problems?	☐ Yes ☐ No
10.	Wear glasses, contacts or protective eyewear?	☐ Yes ☐ No	20.	Traveled outside the country in the past nine months?	☐ Yes ☐ No

Please explain "yes" answers in the space below, noting the number of each question. For travel outside the country, please name countries visited and dates of travel.

This page to be completed by parent/guardian

Camper Name _____ Gender **M F** Birthdate _____
Last First Middle/Nickname MM/DD/YY

IMMUNIZATION HISTORY

A separate printout from the physician's office may take the place of this immunization record.

	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Dose 6 Month/Year
Diphtheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster (dT) or (Tdap)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (Chicken Pox) ☐ Had Chicken Pox Date:						
Meningococcal meningitis (MCV4)						

MEDICAL INSURANCE INFORMATION: This camper is covered by medical/hospital insurance. ☐ Yes ☐ No

Insurance Company _____ Insurance Company Phone Number _____

Policy Number _____ Subscriber _____

Bin #_____ Group #_____ ID#_____ Pen#_____

PLEASE ATTACH A COPY OF BOTH SIDES OF YOUR INSURANCE CARD

HEALTH CARE PROVIDERS

Name of camper's primary doctor(s):_____ Phone: _____

Name of camper's dentist(s):_____ Phone: _____

Name of camper's orthodontist(s):_____ Phone: _____

Parent/Guardian with legal custody to be contacted in case of illness of injury.

Name _____ Relationship to camper _____ Preferred phone #s _____

Home Address _____
If different from above — Street Address — City — State — Zip

Second parent/guardian or other emergency contact:

Name _____ Relationship to camper _____ Preferred phone #s _____

Additional contact in the event that parent(s)/guardian(s) cannot be reached:

Name _____ Relationship to camper _____ Preferred phone #s _____

This page to be completed by parent/guardian

Camper Name _____ Gender **M F** Birthdate _____
Last First Middle/Nickname MM/DD/YY

HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL

ACA accreditation requirements specify exams within 12 MONTHS of camp attendance. A new exam is not necessarily required for camp attendance. A school or sport physical signed by the physician, with an exam date falling within 12 months of the camper's participation at camp, may be substituted for this particular page. The parent must complete all other pages and submit to the camp office.

I examined this individual on (date) _____.

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:

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 camp

SIGNATURE OF LICENSED MEDICAL PROFESSIONAL _____

Printed Name _____ Title _____

Address _____

Phone _____ **Date** _____

This page to be completed by medical professional