



SUMMER AT THE YMCA—2018

Health History Form

This form must be filled out completely, signed by the camper's parent/guardian, and returned with requested documentation to the camp office or YMCA Branch by **JUNE 3.**

Email the completed form to the listed contact.

My camper is attending (check all that apply)

- YMCA Camp Abe Lincoln (camp@scottcountyfamilyy.org)
- Summer Adventures—North (abass@scottcountyfamilyy.org)
- Summer Adventures—West (abass@scottcountyfamilyy.org)
- Summer Adventures—Bettendorf (bloeffelholz@scottcountyfamilyy.org)

Camper's Name _____ Birthday ____/____/____ Age ____

Mailing Address _____ Grade in Fall 2017 _____

_____ Gender Male Female

Camper Lives With _____ Relationship To Camper _____

Primary Guardian's Name & Email _____

Primary Guardian's Phone # _____ Alternate Phone # _____

Secondary Guardian's Name & Email _____

Secondary Guardian's Phone # _____ Alternate Phone # _____

Emergency Contact Name _____ Relation to Camper _____

Emergency Contact Phone # _____ Alternate Phone # _____



CAMPER MEDICAL INFORMATION:

Name of Family Physician _____ Phone # _____

Name of Family Dentist _____ Phone # _____



IMMUNIZATION HISTORY:

I hereby verify that my child is current on all immunizations required for school. Please initial _____

If not, please explain _____

Date of last Tetanus shot ____/____/____



GENERAL HEALTH HISTORY

Please check if any of the below apply.

- | | |
|--|--|
| <input type="checkbox"/> Recent injury, illness, or infectious disease | <input type="checkbox"/> Ever had professional help for behavioral or emotional difficulties |
| <input type="checkbox"/> Chronic or recurring illness/condition | <input type="checkbox"/> Mental health hospitalization |
| <input type="checkbox"/> Ever had surgery | <input type="checkbox"/> Attention Deficit Hyperactivity Disorder |
| <input type="checkbox"/> Ever had seizures | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Skin conditions | <input type="checkbox"/> Tic Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tourette's Syndrome |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Autism Spectrum Disorder |
| <input type="checkbox"/> Sleepwalking or night terrors | <input type="checkbox"/> Behavior Disorder |
| <input type="checkbox"/> History of bedwetting | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Wakes in night to use restroom | <input type="checkbox"/> Obsessive Compulsive Disorder |
| <input type="checkbox"/> History of being afraid of the dark | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> History of noise while sleeping (snore, talks, etc) | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Pervasive Development Disorder |
| <input type="checkbox"/> Heart defect/disease | <input type="checkbox"/> Oppositional Defiant Disorder |
| <input type="checkbox"/> Blood disorder (hepatitis, HIV, clotting, etc) | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Have any restrictions to activities (what cannot be done/adaptations/limitations necessary) |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Dietary Restrictions (vegetarian, vegan, gluten, lactose intolerant, etc) |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Additional concerns Camp should be aware of (behavior, physical, emotional health, etc) |
| <input type="checkbox"/> Chicken Pox | |
| <input type="checkbox"/> Measles/German Measles | |
| <input type="checkbox"/> Mumps | |
| <input type="checkbox"/> Contact lenses | |
| <input type="checkbox"/> Braces, retainers, or other dental items | |


Please explain all checked items _____



ALLERGIES Please check if any of the below apply. If checked, please state if the allergy is mild, moderate, or severe AND if the allergy is contact or airborne.

- | | | |
|--|---|--|
| <input type="checkbox"/> Horses | <input type="checkbox"/> Environmental (Pollen, trees, mold, etc) | <input type="checkbox"/> Peanut/Tree Nut |
| <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Food _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Penicillin | | |

Severity of reaction and action plan for your camper _____

 **MEDICATIONS** Please list **ALL** medications (including over-the-counter and non-prescription) that are taken routinely by the camper. For Camp Abe Lincoln Campers, please bring enough medication to last for the whole week. **ALL** medication must be in its original packaging that identifies prescribing physician (if prescribed), the

- This camper does not take any medication**
- This camper takes routine medication (including vitamins) as follows:**

Medication	Dosage	Times Taken	Reasons for taking

AUTHORIZED PICK UP LIST (INCLUDE PARENTS IF AUTHORIZED TO PICK UP)

Name _____ Relationship: _____

Phone # _____ Alternate Phone # _____

Name _____ Relationship: _____

Phone # _____ Alternate Phone # _____

Name _____ Relationship: _____

Phone # _____ Alternate Phone # _____

Name _____ Relationship: _____

Phone # _____ Alternate Phone # _____

Name _____ Relationship: _____

Phone # _____ Alternate Phone # _____

**THE FOLLOWING SECTION SHOULD BE FILLED OUT FOR
SUMMER ADVENTURES CAMPERS ONLY:**



SHIRT SIZE Please circle your child's t-shirt size. On field trip days, your child will be issued a shirt. Shirts are returned after the field trip and washed for the following week.

Youth: XS S M L

Adult: S M L



SWIMMING ABILITY Please mark the swimming ability of the camper. Participant will still be required to pass a swim test to utilize deep ends (up to 6ft) and/or waterslides (3.5ft depth). The YMCA will provide USCG Lifejackets for daily use.

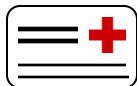
_____ Must wear USCG Lifejacket for entire swim session, regardless of depth.

_____ Can swim with no assistance, does not need USCG Lifejacket.

**THE FOLLOWING SECTION SHOULD BE FILLED OUT FOR
CAMP ABE LINCOLN CAMPERS ONLY:**

The following medications may be dispensed by our Health Administrators. Please cross out any medications which your camper **SHOULD NOT** be given:

Acetaminophen (Tylenol)	Day/Nigh Cold & Flu	Tums	Omeprazole Acid Reducer	Rubbing Alcohol
Kid's Liquid or Chewable Acetaminophen	Cough Drops	Pepto	Chewable Stomach Relief	Aloe Vera Lotion or Spray
Ibuprofen	Cough Syrup	Imodium A-D	Chewable Antacid	Sterile Eye Drops
Kid's Liquid or Chewable Ibuprofen	Nasal Decongestant (Phenylephrine HCL)	Milk of Magnesia	ChlorTabs (Allergy Relief)	Vapor Rub
Latex Band aids	Diphenhydramine HCL (Benadryl)	Hydrocortisone Cream	Loratadine (Allergy Relief)	Epsom Salt
Anti-Itch Cream or Spray	Suphedrine HCL	A & D Skin Protectant	Kid's Liquid Allergy Relief	Hydrogen Peroxide



CAMPER HEALTH INSURANCE INFORMATION:

A photocopy of **BOTH** sides of your health insurance, Medicaid, or Title XIX card must be attached to this form. If you do not have health insurance, please initial here: _____

FOR CAMP USE ONLY

Is all the information current? YES NO Explain _____

Does the camper have medications? NO YES Logged on health book _____

Does the camper have allergies? NO YES Informed Kitchen _____ Counselors _____

Head checked and cleared? YES Date _____

**THE FOLLOWING SECTION SHOULD BE FILLED OUT FOR
ALL SCOTT COUNTY FAMILY Y CAMPERS:**

ADDITIONAL CAMPER INFORMATION Please provide any additional information that you feel our staff should know to make this camp experience successful for your child.

PARENT'S AUTHORIZATION

This health history is correct and accurately reflects the health status of (camper to whom it pertains) _____. S/he has permission to participate in all camp activities except as noted by me and/or an examining physician. 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. If I cannot be reached in an emergency, I give my permission to the physician 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.

The Scott County Family Y (hereinafter referred to as "Y") is not obligated to furnish any insurance under the Y program referred to below although it may do so without any obligation as to the adequacy of any insurance it may furnish. I, the parent/legal guardian of the program participant, agree that they and all individuals participating in Y programs in any capacity, will not be liable for any causes of actions, claims and injuries arising out of the participation of the applicant in the Y programs, and hereby release all said individuals from such claims and liabilities. The undersigned acknowledges that in all camp activities there are certain risks of physical injuries and all participants participate at their own risk. I, as parent/legal guardian of a program participant under the age of 18, consent to the participation of the applicant in Y programs listed on the registration from under the above mentioned conditions.

I DO _____ DO NOT _____ give consent to be photographed, videotaped and/or filmed while participating in any YMCA activities and for the resulting photos, etc. to be used by the YMCA for educational and promotional purposes. I have read and understand above.

Primary Guardian Signature

Date