Office Use ONLY:
Program(s)_____

Arrival Date: _____ Departure Date:_____

2018 CAMP HEALTH HISTORY & EXAMINATION FORM FOR CHILDREN, YOUTH & ADULTS

PLEASE SUBMIT ENTIRE FORM TOGETHER
The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care.

Camper Details

Name _____ **Date of Birth** _____ **Age at camp** ___ **Gender M / F**
Last **First** **MI** *Circle One*

Contact Information

Parent or Guardian Name_____ Relationship _____

Home Address _____
Street Apt.# City State Zip

Home Phone (___)_____ Business Phone (___)_____ Cell Phone (___)_____

Second Parent/Guardian or Emergency Contact _____ Relationship _____

Home Phone (___)_____ Business Phone (___)_____ Cell Phone (___)_____

*If not available in an emergency, notify: Name*_____ Relationship _____

Home Phone (___)_____ Business Phone (___)_____ Cell Phone (___)_____

Family Medical Information

Name of family physician _____ Phone (___)_____

Is the participant covered by medical/hospital insurance? (If none then write NONE)_____

If yes indicate plan name or carrier _____Policy or group # _____

Name of insured _____ Relationship to participant_____

Prescription Plan Name (If none then write NONE)_____ Plan Name_____

THIS FORM MUST BE SIGNED OR YOUR CHILD WILL NOT BE ABLE TO ATTEND CAMP

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

Emergency Authorization

This health profile is correct and accurately reflects the health status of the individual to whom it pertains. This camper has my permission to attend Fairview Lake YMCA Camps. This camper has my permission to participate in all camp activities except as documented by me and/or an examining physician. The camp nurses have my permission to inform appropriate staff members of this camper's medical condition(s) or individual needs on a "need to know" basis.
ACA *Permission to Treat*. I give permission to the physician selected by camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and emergency situations. If I cannot be reached in an emergency, I give permission to the physician selected by camp to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for this child. I give permission to photocopy this form.

Signature of parent/guardian or adult camper/staff _____ Date _____

Please Note: This signature includes parental permission for medications listed on page 3

Camper's name _____ **PAGE 2**
Last First

Health History

Allergies (place an "x" next to appropriate selection)

____ No Known Allergies

____ Allergic to: (Describe below any food, medication, , etc. allergies- **PLEASE PRINT CLEARLY**)

_____

_____

_____

List any operations or serious injuries (with dates) _____

_____

List any additional health history concerns/comments including any information about the participant's behavior and physical, emotional, or mental health that the camp should be aware of: _____

_____

_____

_____

Immunization Records

Vaccinations are required by the NJ Department of Health prior to camp attendance. (Check One)

☐ I attest, by my signature following this statement, that all immunizations required by the NJ Department of Health for my child's participation in camp are up to date and that my child has a current DTap shot with the month and year stated below.

☐ Or, I attest that I have signed and provided to the Y a waiver exempting my child from vaccination due to religious or other reasons.

Date of last DTap shot: Month_____ Year_____
All immunizations are up-to-date. ___ YES ___ NO

Current or Recurring Medical Conditions

e.g. Heart Defect/Disease, Convulsions, Diabetes, Bleeding/Clotting, Asthma, Hypertension, Psychiatric Treatment, ADD/ADHD, Bedwetting

List any current medical conditions (If none then please note this): _____

_____

_____

_____

List any current dietary restrictions: _____

List any activities your child should restricted from: _____

For Female

Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____

Camper's name _____ **PAGE 3**

Last First

Medications (this includes both prescription and over-the-counter medications- including vitamins- you will send to camp)

*Please place an "x" next to the appropriate response below

_____ This camper takes **NO MEDICATIONS** on a regular basis.

_____ This camper **WILL TAKE MEDICATION(S)** on a regular basis at camp this summer.

IF YOU SELECTED THE 2nd RESPONSE ABOVE, YOU MUST COMPLETE THE FAIRVIEW LAKE "MEDICAL AUTHORIZATION FORM". This includes both prescription and over-the-counter medications- including vitamins- you will send to camp. The Medical Authorization Form is part of the Health History Form (Medication) document.

Standard Over the Counter Medications - The following over the counter medications are available in the health center. If your child requires daily medications, please send them in the original packaging. These medications can be administered by a Registered Nurse per label instructions by age and weight only if ***Parent written permission*** is on file in the Health Center.

Every YES or NO must be circled in the last column by parent/guardian.

Key: ***PRN*** *(if needed)* ***PO*** *(taken by mouth)* ***Topical*** *(applied to skin)* ***Q*** *(every)*

Drug Name	Route	Schedule & Indications	To be administered if needed Yes / No
Ibuprofen (e.g. Advil, Motrin)	By Mouth / PO (Chewable tabs, pills or liquid)	Q 6h as needed for pain or fever>__-F, cold symptoms, toothache, muscle aches	Yes or No
Acetaminophen (e.g. Tylenol)	By Mouth / PO (Chewable tabs, pills or liquid)	Q 4h as needed for pain or fever>__-F cold symptoms, toothache, muscle aches	Yes or No
Robitussin	By Mouth / PO (liquid)	Q 4h for coughs	Yes or No
Cough drops and Lozenges	By mouth (lozenges)	Q 2h as needed for coughs/sore throats	Yes or No
Diphenhydramine (e.g. Benadryl)	By Mouth / PO / Topical (pills, liquid, or spray)	Q 6h as needed for allergic reaction, hives, insect bites	Yes or No
Epinepherine	Injectable	Allergic reaction difficulty swallowing or breathing	Yes or No
Pseudoephedrine (e.g. Sudafed)	PO (Chewable tabs, pills or liquid)	Q 4h nasal/sinus congestion, hay fever, allergies Not more than 4 doses in 24 hours	Yes or No
Antacid (e.g. Mylanta, Tums, Pepto Bismal)	PO (pills or liquid)	For gas, heartburn, indigestion, upset stomach	Yes or No
Ivy Block and Tecnu	Topical (cream)	Q 6h for contact with poison ivy	Yes or No
Calagel, Calamine and Hydrocortisone	Apply Topically (cream or gel)	Q 4h for insect bites, rash, skin irritation	Yes or No
Bacitracin, First Aid Cream	Topical (ointment)	Q 4h for cuts, scrapes, signs of irritation	Yes or No
Cooling Gel and Aloe	Topical (cream or gel)	Q 4h for burns, sunburn, wind burn	Yes or No
Muscle Rub	Topical (cream)	Minor muscle strains or pains	Yes or No
Orasol, Ambesol and Abreva	Topical (cream or liquid)	Oral herpes, cold sores, toothache	Yes or No
Medicaine	Topical (liquid)	Apply once for insect stings	Yes or No
Nix	Topical (liquid)	For head lice	Yes or No

Did you CIRLCE a response for each of the Drugs listed (REQUIRED)? _____ YES Incomplete forms will be returned.

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

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Programs 2018:

PARENT/COUNSELOR CONFIDENTIAL FORM

Please Complete and Return this form prior to your camper's arrival.

Instructions: This form is designed to improve communication between Camp and the families we serve. Please take time now to complete and return this form prior to your child's arrival at camp. Following your child's stay, this form will be returned to you with a camper evaluation completed by your child's cabin leader.

SECTION A

Camper's name: _____ Nickname: _____

Gender: _____ Dates in Camp: from _____ until _____

Age _____ School grade in Fall: _____ With whom does child live? _____

Has child been away from home before? _____

What does he/she like to do best? _____

Special talents or abilities: _____

_____

If there is some activity your child wants particularly to do at Camp, please name it: _____

_____

How does your child get along with others of the same age? _____

_____

Does your child have any serious fears? If so, please tell us about them: _____

_____

Are there any problems which may confront your child while at Camp? i.e., homesickness, bedwetting, sleepwalking, anxiety, moodiness, allergies, etc: _____

_____

_____

Please list two objectives you have for your child at Fairview Lake YMCA Camps, in order of importance:

1. _____ 2. _____

Are there any events that have occurred in your child's life over the past 12 months that camp should be aware of (i.e. death in family, suspension, seeing a counselor)? _____

_____

Please indicate health, behavioral, or dietary problems staff should be aware of: _____

_____

Any additional information you wish to share with your camper's counselor please do so on a separate sheet of paper.