

LEADERSHIP **12** Sherman Lake YMCA HEALTH FORM

Camper Name _____ Nickname _____ Age _____ Birth date _____ Sex: M F

Camps and sessions enrolled _____

Parent Name(s) _____ Hm Phone _____ Wk Phone _____ Cell Phone _____

Are child's parents living together? _____ If no, who is the custodial parent? _____

Emergency Contact _____ Phone _____ Family Physician _____ Phone _____

Dentist/Orthodontist _____ Phone _____

Medical Insurance Company _____

Policy Number _____ Subscriber _____

MEDICAL INFORMATION

List current medications: _____

May over the counter medication be given to camper for aches and pains?

Yes No

IMPORTANT: Medications must be sent with instructions. Ask your pharmacist for an extra labeled container with the two week dosage to be given to your child while at camp. Medication must be given to camp staff for Leadership Camp check-in. Any unused medication will not be returned and will be properly disposed.

Health History

- | | | |
|--|---|--|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Anorexia Nervosa/Bulimia | <input type="checkbox"/> Current Infectious Diseases (specify) _____ |
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Cerebral Palsy | |
| <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Down's Syndrome | |
| <input type="checkbox"/> Convulsion/Seizures | <input type="checkbox"/> Spina Bifida | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> PMS/Menstrual Problems | |
| <input type="checkbox"/> Seizures past year | <input type="checkbox"/> Active Bedwetting | ALLERGIES: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lactose Intolerant | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Bleeding/Clotting | <input type="checkbox"/> Fainting, Dizziness | <input type="checkbox"/> Ivy Poisoning, etc. |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Insect Stings |
| <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Surgery: _____ | <input type="checkbox"/> Drugs (specify) _____ |
| <input type="checkbox"/> Positive TB Test | <input type="checkbox"/> Chronic Illness: _____ | <input type="checkbox"/> Food (specify) _____ |
| <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Recent Injury: _____ | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Hospitalized: _____ | |
| <input type="checkbox"/> Skin Problems | | |
| <input type="checkbox"/> Back/Joint Pain | | |
| <input type="checkbox"/> Hearing Impairment | | |

NONE OF THE ABOVE

NO ALLERGIES

If you answered YES to any of the above items, please explain below. Include the following **1)** specify symptoms, **2)** how long symptom/condition lasts, **3)** frequency of occurrence, **4)** how you care for symptom/condition, **5)** how symptom/condition restricts activity in any way. You may include a separate sheet to fully explain. _____

Does the camper wear glasses, contacts or protective eyewear?

Yes No

Does your child require any special assistance in school?

Please explain: _____

Dietary Concern: diabetic lactose intolerant vegetarian

picky other (specify): _____

Has the camper seen a professional to address mental/emotional health concerns? Yes No

Significant life events or home situations that affect your camper's life? (divorce, abuse, adoption, death of a loved one) _____

I have reviewed the program and camp activities and feel the camper can participate without restrictions.

Restrictions or adaptations needed: _____

General Release of Liability and Authorization for Treatment

This health history is correct to the best of my knowledge, and the person herein described has permission to engage in all camp activities except as noted. Authorization for Treatment: I hereby give permission to the medical personnel selected by the camp staff to order X-rays, routine tests, treatment, and necessary 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 staff to secure and administer treatment, including hospitalization, for my child as named above. These completed forms may be photocopied for trips out of camp. In consideration for being allowed to participate in the YMCA's programs, I agree to assume the risk of such activities and programs, and I further agree to hold harmless the YMCA and its staff members conducting the activities from any and all claims, suits, losses, or related causes of action for damages, including, but not limited to, such claims that may result from injury or death, accident or otherwise, during or arising in any way from the activities. I grant permission for me or my child to participate in all planned camp activities including out-of-camp trips by van or bus, hiking or horseback riding, understanding that competent leadership is provided. The YMCA is not responsible for lost, stolen or damaged personal articles. I also authorize the YMCA to have and use photographs, slides, or video tapes of me, my child, or my family as may be needed for its public relations programs. I acknowledge that this General Release of Liability and Authorization for Treatment of the YMCA is binding on me personally and on my heirs, personal representatives, successors and assigns.

Signature of parent or guardian _____

Date _____

Note: LEADERSHIP CAMPERS Please download health physical form and return. The State of MI Licensing Department and the American Camp Association's mandatory standards require this form to be signed by a licensed physician and on file in our office while a camper is at camp. Campers may not participate in any camp program until this form is present at Sherman Lake YMCA Outdoor Center. Please call 269-781-3000 if you need the form mailed to you.

Demographics Because we receive grant funding, we have been requested to track the following demographics. Information for grant reporting purposes only.

Ethnicity African American Asian American Caucasian Hispanic Multi-Racial Native American Other

Number of people in household? _____

Household Income: Below \$12,000 \$12,500-19,000 \$20,000-34,000 \$35,000-49,000 \$50,000-75,000 Above \$75,000

Camper Immunization History

Provide the month and year for each immunization.

Starred (*) immunizations must be current.

	MONTH	YEAR
Diphtheria, tetanus, pertussis* (DTaP) or (TdaP)		
Mumps, measles, rubella* (MMR)		
Polio* (IPV)		
Haemophilus influenza type B (HIB)		
Pneumococcal (PCV)		
Hepatitis B		
Hepatitis A		
Varicella (chicken pox)		
Meningococcal meningitis (MCV4)		
Tuberculin Test (TB) Date: _____	Negative _____	Positive _____

All immunizations up to date?

Yes No

Camper Information: The following questions are designed to help your child's counselor prepare a great camp experience for him/her.

Did your child choose to come to camp, did you decide or was the decision mutual? _____

Former Sherman Lake Camper? Yes No # Years _____

Does your child make friends easily? Yes No

Does your child adapt well to new situations? Yes No

Attitude towards adults:

friendly resentful indifferent helpful seeks attention

Other (specify): _____

What camp activities most interest your child? _____

Swimming skills: Enjoys the water Jumps from the side

Comfortable in chest-deep water Floats Swims 10-20 yds.

Swims 25 yds. Comments: _____

What would you like your counselor to know about your child? _____

Please share tips for a successful camp experience: _____