Wayne County YMCA After School – 2017/18
Camper Health & Permission Form

*****A copy of your child's last doctors physical is required to register your child for After School.*****

Name: _____ Gender: _____ DOB ___/___/___ Age: ____ Grade: ____ Member: ___

Address: _____ Email: _____

Parent/Guardian's Name: _____ Employer: _____

Cell #: _____ Home#: _____ Work#: _____

Parent/Guardian's Name: _____ Employer: _____

Cell #: _____ Home#: _____ Work#: _____

Are there any siblings in camp? If so, please name. _____

In your opinion, is this child physically and emotionally able to participate in a day camp program like the one described in our literature? Y N If no, please explain: _____

Medical Treatment Policy: I understand that the YMCA does not normally administer any medication and will do so only when directed in writing by a parent or guardian. However I understand, in the event of an emergency in which a parent, guardian or emergency contact cannot be reached, that Emergency Medical Staff and the YMCA may take appropriate action to best serve the interest of my child. I understand in the case of an emergency situation, when medical attention is necessary, that the camper's parents or guardians will be responsible for any medical cost. Therefore, in consideration of your acceptance of this registration: I hereby for myself, my heirs and assignees waive any and all claims for damages that I might have against the Wayne County YMCA staff, volunteers, the Board of Director's, the Honesdale Borough, Wayne Highlands & Wallenpaupack School Districts, Transportation Contractors and all field trip sites, for any and all injuries suffered by my child.

I, _____ (Parent or Guardian) have read, understand and agree to the Medical Treatment Policy stated above.

I, _____ (Parent or Guardian), authorize the YMCA to obtain emergency medical treatment for my child, _____, in case of emergency.

Emergency Contact (if parents cannot be reached)

Name: _____ Relationship: _____

Cell #: _____ Home#: _____ Work#: _____

Medication Being Taken:

Does this child take any medication on a regular basis? ☐ Yes ☐ No (If *no* proceed to back, if *yes* indicate below)

Med. #1 _____ Dosage _____

Reason for taking _____

Med. #2 _____ Dosage _____

Reason for taking _____

Will any of these medications need to be administered during camp hours? ☐ Yes ☐ No

If yes, which ones_____

*****Please remit a physician's note denoting the prescription and dosage with this form. *****

Camper's Medical History & Insurance Information 2017/18

General Questions (Explain yes answers below)

Has/Does the participant:	yes	no
1. Had a recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Ever passed out after exercise?	☐	☐
11. Ever been dizzy before or after exercise?	☐	☐
12. Ever had seizures?	☐	☐
13. Ever had chest pain before or after exercise	☐	☐
14. Ever had high blood pressure?	☐	☐
15. Ever been diagnosed with a heart murmur?	☐	☐
16. Ever had back problems?	☐	☐
17. Ever had problems with joints (e.g. knees, ankles)	☐	☐
18. Have any orthodontic appliances being brought to camp?	☐	☐
19. Have any skin problems? (e.g. itching, rash, acne)	☐	☐
20. Have Diabetes?	☐	☐
21. Have Asthma?	☐	☐
22. Have mononucleosis in the last 12 months?	☐	☐
23. Had problems with diarrhea/constipation?	☐	☐
24. Have problems with sleep walking?	☐	☐
25. If female, have an abnormal menstrual history?	☐	☐
26. Have a history of bedwetting?	☐	☐
27. Ever had an eating disorder?	☐	☐
28. Ever had emotional difficulties for which professional help was sought?	☐	☐

Please explain any (yes) answers and note the question # _____

_____

Are there any other restrictions, limitations or conditions (allergies, etc.) _____

_____

Which of the following has the participant had?

- ☐ Measles
- ☐ Chicken Pox
- ☐ German Measles
- ☐ Mumps
- ☐ Hepatitis

___Date of last TB Mantoux Test

Result_____

Please give the date of the last immunization for:

Date:	Vaccine	Date:	Vaccine
_____	DTP	_____	Varicella Zoster
_____	Rubella	_____	TD (Tetanus / diphtheria)
_____	Tetanus	_____	Haemophilus influenza B
_____	Polio		
_____	Hepatitis B		
_____	Measles (hard or red measles or rubella)		

Name of Primary Care Physician: _____ Phone: _____

Address: _____

Insurance Carrier: _____ Group & ID #: _____

Name of Insured: _____ Relationship to camper: _____

Parent or Guardian Authorization: To the best of my knowledge this health history is correct and complete, and the person herein described has permission to engage in all camp activities except as noted.

Parent or Guardian's Signature: _____ Date: _____

Printed Name of Parent or Guardian: _____