



- This camper is lactose-intolerant. Check one:
  - This camper uses a product like Lactaid and/or can self-manage the intolerance.
  - This camper needs a lactose-free diet that includes no lactose in baked items (i.e., breads, cookies, cakes).

**CHRONIC CONCERNS:** Check all that pertain to this camper and provide information about supportive health care.

- This camper has no chronic health concerns and is capable of full participation in this program.
- This camper has the following chronic health concern(s):

- Asthma
- Menstrual Cramps
- Headaches
- Frequent ear infections
- Sleepwalking
- Frequent colds
- Diabetes
- Bedwetting
- Other (please describe) \_\_\_\_\_

Provide information about supportive health care needed for each checked item:

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**MEDICATION:** Provide complete information. Bring enough medication to last the entire session. ALL medications MUST be in pharmacy containers and appropriately labeled (see Parent Handbook).

- This camper does not take any medication.
- This camper takes routine medication (include vitamins) as follows (attach more information if needed):
  - #1 Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ How often each day? \_\_\_\_\_  
Reason for taking: \_\_\_\_\_
  - #2 Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ How often each day? \_\_\_\_\_  
Reason for taking: \_\_\_\_\_
  - #3 Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ How often each day? \_\_\_\_\_  
Reason for taking: \_\_\_\_\_

**These medications, stocked in the YMCA Camp Lakewood TLC, are used to manage illness or injury and dispensed as directed by our medical protocols. Cross out those, which your camper should not be given:**

- |                            |                            |                         |
|----------------------------|----------------------------|-------------------------|
| Acetaminophen              | Ibuprofen                  | Silvadene (Burn Cream)  |
| Aleve                      | Imodium AD                 | Sudafed                 |
| Aloe Vera After Sun        | Ivy Dry                    | Swimmer's Ear           |
| Caladryl                   | Maalox                     | Tinactin                |
| Calamine Lotion            | Multi Symptom Cold Tablets | Triple Antibiotic Cream |
| Choloraseptic Throat Spray | Mylanta                    | Tums                    |
| Generic Cough Drops        | Nighttime Cold Formula     |                         |
| Generic Cough Syrup        | Pepto Bismol               |                         |

**IMMUNIZATION HISTORY:** Provide the month and year for each immunization.

Immunization	Dose 1	Dose 2	Dose 3	Dose 4
DTP: Diphtheria, Tetanus, Pertussis				
TD: Tetanus Booster		<i>Must be current within past 10 years</i>		
MMR: Mumps, Measles, Rubella		<i>Measles booster (required prior to 7th grade)</i>		
IVP/OPV: Polio				
HepB: Hepatitis B				
Hib: H. Influenzae, type b				

**GENERAL HISTORY:** Check "Yes" or "No" for each statement.

- This camper has had chicken pox.....  Yes  No
- This camper has had mononucleosis in the past 12 months.....  Yes  No
- This camper's hearing is within normal range.....  Yes  No
- This camper is prepared to fall asleep at night without supports such as reading or listening to music...  Yes  No
- This camper typically makes noise while sleeping (snores, talks in sleep, etc.).....  Yes  No
- This camper usually gets up at night to use the bathroom.....  Yes  No
- This camper shares his/her bedroom at home with at least one other person.....  Yes  No
- This camper uses contact lenses (consider bringing an extra pair) or glasses to correct vision.....  Yes  No
- This camper has an illness, injury or surgery, which would affect program participation.....  Yes  No
- For girls: This camper knows about menstruation and/or has a normal menstrual history.....  Yes  No
- This camper has been hospitalized.....  Yes  No
- This camper has or has had seizures.....  Yes  No

**GENERAL HISTORY CONTINUED:** Please explain any "yes" answers.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of camper's physician: \_\_\_\_\_ Office Phone: (\_\_\_\_\_) \_\_\_\_\_

Name of camper's orthodontist: \_\_\_\_\_ Office Phone: (\_\_\_\_\_) \_\_\_\_\_

**MENTAL AND EMOTIONAL HEALTH:** Check "Yes" or "No" for each statement.

- This camper has been diagnosed with Attention Deficit Disorder (ADD) or AD/HD.....  Yes  No
- This camper has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder.....  Yes  No
- This camper has or has had an eating disorder.....  Yes  No
- This camper has an emotional health concern.....  Yes  No
- This camper has a learning disability.....  Yes  No
- This camper has seen or is currently seeing a professional to address mental/emotional health concerns.....  Yes  No

If "yes" was the answer to any question in this section, please attach a statement from your physician or psychiatrist which:

- (a) Describes the concern and the camper's management plan (including medications),
- (b) Describes the behaviors which would indicate to our staff that your camper needs professional referral, and
- (c) Provides a recommendation for participation in the YMCA Camp Lakewood program.

**What have we forgotten to ask?** Provide additional information about your child's health, which may have been neglected, on this form. We are particularly interested in information which has impact upon your child's ability to fully participate in our program. Provide additional information about your child's health, if needed, by attaching a page to this form.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Billing Information for Health Care:** Parents/Guardians are financially responsible for health care given by an out-of-camp provider. To whom should we route charges for this camper's health care? **Include a copy of an insurance card if appropriate. Copy both sides of the card so addresses and telephone numbers are available.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

- Arrange presauthorization for your child's medical care if your insurance requires this.
- We will have you call the Doctor Office with your credit card number for payment of treatment.
- We will have you call our pharmacy with your credit card number if we anticipate that a prescription will be ordered.

**PARENT CONTACT INFORMATION:** We will call in an emergency or if we have questions about your child. Provide contact information for other people who know your child and with whom we can consult if we cannot reach you. We assume you have spoken with these individuals and they are willing to assist should the need arise.

Parent/Guardian	Daytime	Evening
Name: _____	Telephone: (_____) _____	Telephone: (_____) _____

Alternate	Relationship
Contact: _____ Telephone: (_____) _____	to Camper: _____

Alternate	Relationship
Contact: _____ Telephone: (_____) _____	to Camper: _____

**PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE:** This health history is correct, and the person described has permission to participate in all camp activities except as noted by me and/or the examining physician. I give permission to the physician selected by YMCA Camp Lakewood to order X-rays, routine tests and treatment for the health of my child. If I cannot be reached in an emergency, I give permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for the child. This form may be photocopied. The YMCA Camp Lakewood has permission to obtain a copy of my child's health record from the providers they access to treat my child. I understand that information about my child's health will be shared on a "need to know" basis with other Camp Lakewood Staff.

**Signature of Custodial Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**MEDICAL EXAMINATION – To be filled out by Licensed Medical Personnel:** *This examination should be performed within 24 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities. Laboratory tests done at discretion of physician.*

**To Physicians and Nurse Practitioners:** This child has enrolled in a summer residential program at YMCA Camp Lakewood. The program includes physical activity (i.e., swimming, soccer, volleyball) and takes place in Missouri’s Mark Twain National Forest. Our healthcare staff will use your information to help meet the health needs of the person described.

I have examined \_\_\_\_\_ on this day, \_\_\_\_\_.  
(First Name) (Last Name) (Date)

**CODE: S = Satisfactory N = Not Satisfactory X = Not Examined**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ Hct or Hgb Test: \_\_\_\_\_ Urinalysis: \_\_\_\_\_

Eyes	_____	Lungs	_____
Glasses	_____	Abdomen	_____
Ears	_____	Hernia	_____
Nose	_____	Extremities	_____
Throat	_____	Posture	_____
Heart	_____	Skin	_____
Genitalia	_____		

**RECOMMENDATIONS AND RESTRICTIONS AT CAMP:**

Describe the treatment(s) to be continued at camp and any significant physical findings regarding this camper and/or any limitations, which may impact the child’s participation in our program:

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I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

**Signature of Licensed Medical Personnel:** \_\_\_\_\_

Printed: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_