FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA CAMP LAKEWOOD
13528 State Highway AA, Potosi, MO 63664
Phone: 573-438-2155
Fax: 573-438-3913
www.camplakewood.org

CAMPER HEALTH FORM 2019

YMCA CAMP LAKEWOOD

HEALTH HISTORY: To be completed and signed by parent/legal guardian

Return this form to the address below at least **3 weeks** prior to start of camp

YMCA Camp Lakewood
13528 Highway AA
Potosi, MO 63664

Fax #: 573-438-3913
Email: camplakewood@gwrymca.org

Dates will attend camp _____ Session # _____

Camper Name _____
First Middle Last

Address _____

City _____ State _____ Zip_____

☐ Male ☐ Female Birth Date _____ Age _____
Month/Day/Year

Social Security Number _____

Parent/Guardian with legal custody to be contacted in case of illness or injury:

Name _____ Relationship to Camper _____

Preferred Phones (_____) _____ (_____) _____

Second Parent/Guardian or other emergency contact

Name _____ Relationship to Camper _____

Preferred Phones (_____) _____ (_____) _____

Additional contact in event parent(s)/guardian(s) cannot be reached

Name: _____ Relationship to Camper _____ Preferred Phone (_____) _____

Last Name:

First Name:

MEDICATIONS

☐ This camper will **not** take any daily medications while attending camp

☐ This camper will take the following medication(s) while at camp:

"Medication" includes vitamins & natural remedies. We require **original pharmacy containers** with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.

Medication Name	Date Started	Reason for Taking It	When it is Given	Amt/Dose Given	How it is Given
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Other Time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Other Time: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Other Time: _____		

IMMUNIZATION HISTORY

Provide the month and year for each immunization. Starred (*) immunizations must be current. **Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.**

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, Tetanus, Pertussis* (DTaP) or (TdaP)						
Tetanus booster* (dT) or (TdaP)						
Mumps, Measles, Rubella* ((MMR)						
Polio* (IPV)						
Haemophilus Influenza Type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐ had chicken pox Date:_____						
Meningococal Meningitis (MCV4)						

If your camper has NOT been fully immunized, please sign the following statement:

Tuberculosis (TB) Test	Date:	☐ Negative ☐ Positive

I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian _____ *Date* _____

GENERAL HISTORY

This camper has had mononucleosis in the past 12 months..... ☐ Yes ☐ No

This camper's hearing is within normal range (If no, explain below)..... ☐ Yes ☐ No

This camper is prepared to fall asleep at night without supports such as reading or listening to music (If no, explain below)..... ☐ 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 (If yes, explain below)..... ☐ Yes ☐ No

This camper has been hospitalized (If yes, explain below)..... ☐ Yes ☐ No

For girls: This camper knows about menstruation and/or has a normal menstrual history (If no, explain below)..... ☐ Yes ☐ No

Explanation _____

_____

_____

_____

HEALTH CARE PROVIDERS

Name of camper's physician _____ Office Phone: (_____) _____

Name of camper's dentist _____ Office Phone: (_____) _____

Name of camper's orthodontist _____ Office Phone: (_____) _____

MENTAL AND EMOTIONAL HEALTH

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 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 issues..... ☐ 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).

WHAT HAVE WE FORGOTTEN TO ASK?

Provide any additional information about your child's health, if needed, below or by attaching a page to this form. We are particularly interested in information which has impact upon your child's ability to fully participate in our program.

_____

_____

_____

_____

MEDICAL INSURANCE INFORMATION

This camper is covered by family medical/hospital insurance ☐ Yes ☐ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable

Insurance Company Name _____

Policy Number _____

Arrange pre-authorization for your child's medical care if your insurance requires this.

We will have you call the Doctor Office or Pharmacy with your credit card number for payment of treatment or prescription.

Subscriber Name _____ Insurance Co. Phone Number (_____) _____

PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE

This health history is correct, and the person described as permission to participate in all camp activities except as noted by me and/or the examining physician. I give permission to the medical staff selected by YMCA Camp Lakewood to order x-rays, routine tests and treatment for the health of my child. In case of accident or illness, the YMCA is authorized to secure emergency treatment. 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 my child. This form may be photocopied. 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 _____

Please contact the camp office at 573-438-2155 (direct line) if you would like a "Waiver for Permission to Treat".

MEDICAL EXAMINATION

To only be filled out by licensed medical personnel

This examination should be performed **within 12 months of arrival at camp**. Examination for some other purpose within this period is acceptable. We will accept your doctor's form. It's not necessary to use this form. Examination is for determining fitness to engage in strenuous activities. Laboratory tests done at discretion of physician.

TO PHYSICIAN AND NURSE PRACTITIONERS: This child has enrolled in a summer residential program at YMCA Camp Lakewood. The program includes physical activity (ie. swimming, soccer, volleyball, etc.) and takes place in Missouri's Mark Twain National Forest. Our health care staff will use your information to help meet the health needs of the person described.

I have examined _____ on this day _____

CODE: S = Satisfactory N = Not Satisfactory X = Not examined

Height: _____ Weight: _____ BP: _____ Hct or Hgb Test: _____ Urinalysis: _____

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

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.

_____

_____

_____

_____

_____

_____

_____

Diagnosis: _____

Adaptations/Concerns: _____

_____

Please indicate the substantial functional limitations for the above-named child:

___ Capacity for Independent Living	___ Receptive and Expressive Language	___ Learning
___ Self-Care	___Self-Direction or Economic Self-Sufficiency	___ Mobility

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 Name: _____ Title: _____

Address: _____

Phone: _____ Date: _____