

**YMCA OF METROPOLITAN MILWAUKEE  
2010 CAMP HEALTH EXAMINATION FORM**



**This form MUST BE RETURNED BY JUNE 1 to the Camp Office**

This side to be filled out by parent/guardian and checked with physician at time of examination.

**CAMPER'S PERSONAL INFORMATION**

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
 Boy \_\_\_ Girl \_\_\_ Birthday \_\_\_/\_\_\_/\_\_\_ Age on first day of session \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

**GUARDIAN INFORMATION**

Mother/Guardian First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
 Birthday \_\_\_/\_\_\_/\_\_\_ E-Mail \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
 Address \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ex. \_\_\_  
 City, State, Zip \_\_\_\_\_  
 Father/Guardian First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
 Birthday \_\_\_/\_\_\_/\_\_\_ E-Mail \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_  
 Address \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ex. \_\_\_  
 City, State, Zip \_\_\_\_\_

**EMERGENCY CONTACTS** (If parent/guardians listed above are not available)

Name	Relationship	Daytime Phone	Night Phone
_____	_____	_____	_____
_____	_____	_____	_____

**HEALTH HISTORY**

Check all that apply and give dates. *If you check any \* items, a health form addendum must be completed and returned.*

ALLERGIES*	DISEASES	OTHER
Hay Fever _____	Chicken Pox _____	Ear Infections _____
Ivy Poisonings _____	Measles _____	Rheumatic Fever _____
Insect Stings* _____	German Measles _____	Seizures _____
Penicillin _____	Mumps _____	Skin Conditions _____
Other Drugs _____	Asthma * _____	Behavioral Issues* _____
Food* _____	Diabetes* _____	Special Needs* _____

Any specific activities to be restricted \_\_\_\_\_  
 Operations or Serious Injuries (dates) \_\_\_\_\_  
 Chronic or Recurring Illness\* \_\_\_\_\_  
 Other Diseases or Details of Above \_\_\_\_\_

*Please notify camp if this camper is exposed to any communicable disease during the three weeks prior to camp.*

Select One:  This child takes no medications on a routine basis.  
 A health form addendum accompanies this form detailing this child's medications and dosing schedule.

**IMMUNIZATION HISTORY**

Please record the dates and immunizations with most recent booster doses. This information is required for camp attendance.

DTP Series _____ booster _____	Tetanus Booster _____
Polio OPV (sabin) _____ booster _____	Typhoid _____
Measles Vaccine (live) _____	Tuberculin Test _____
German Measles (Rubella) _____	Mumps Vaccine (live) _____
Smallpox _____	Varicella Vaccine (chickenpox) _____
Other/Additional Immunizations _____	

What have we forgotten to ask? Do you have any other concerns/comments for the Health Officer? \_\_\_\_\_

Camper's First Name \_\_\_\_\_ Last Name \_\_\_\_\_

**HEALTH INSURANCE COMPANY INFORMATION** *Must include a photocopy of both sides of insurance card*

Insurance Company \_\_\_\_\_ Group and/or Policy Number \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Policy Holder's Birth date \_\_\_/\_\_\_/\_\_\_

**PARENT'S MEDICAL AUTHORIZATION AND GENERAL PARTICIPATION AGREEMENT:**

By signing, the parent/guardian certifies approval of good health of the camper, and in the event that I cannot be reached in an emergency, authorize the YMCA health care staff/volunteers to render first aid; give permission to the physician selected by the YMCA of Metropolitan Milwaukee to hospitalize, secure proper treatment for and to order injections, anesthesia, or surgery for my child as named above. I give permission to camp health officer/doctor to dispense over-the-counter products (Tylenol, cough syrup, etc.) and prescriptions as needed. Prudent attempts will be made to contact parents immediately. I agree to release the YMCA of Metropolitan Milwaukee from any liability for the risk of illness, accidents, or injury. I agree to pay the balance of the camp fees no later than June 1 and understand the YMCA cannot hold reserved space beyond that date without full payment. Camp fees are not refundable without a doctor's authorized medical reason. I understand that no refunds are given if a child leaves early because of homesickness or disruptive behavior as determined by the Camp Director. The deposit is not refundable or transferable under any circumstances. I grant permission for the applicant to participate in all planned camp activities including participation in high adventure elements, swimming, canoeing, hiking, skateboarding or horseback riding. The YMCA is not responsible for lost, stolen, or damaged articles. I also authorize the YMCA to have and use photographs, slides and videotapes of the person named in this application as may be needed for its public relations programs. I give permission for the child named to attend traveling field trips, supervised by the YMCA staff members at all times, to and from camp by van, hired bus company or by foot or bike. I agree to waive claims against the YMCA and its members and volunteers to injuries or damages that may result from the conduct of other persons including participants in the YMCA programs.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL EXAMINATION:** To be filled out by licensed physician. This examination **must be performed within 24 months of arrival** at camp. Examination for some other purpose within this period of time is acceptable. Examination is for determining fitness to engage in strenuous activities.

Date of Exam: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ B.P. \_\_\_\_\_

(Please indicate yes for satisfactory and no if there are any concerns. Please include explanations of negative responses)

Eyes	_____	Extremities	_____
Glasses	_____	Posture (Spine)	_____
Ears	_____	Skin	_____
Nose	_____	Abdomen	_____
Lungs	_____	Allergy:	_____
Throat	_____	Please Specify	_____
Teeth	_____	Heart	_____

General Appraisal: \_\_\_\_\_

**(For Girls and Women)**

Has this person menstruated? \_\_\_\_ If not, has she been told about it? \_\_\_\_ If so, is her menstrual history normal? \_\_\_\_

Special considerations: \_\_\_\_\_

**RECOMMENDATIONS AND RESTRICTIONS WHILE IN CAMP**

Special diet \_\_\_\_\_

Special medicine (name it) \_\_\_\_\_

Swimming, diving \_\_\_\_\_

Strenuous activity \_\_\_\_\_

Other \_\_\_\_\_

I have examined the person herein described and have reviewed her/his health history. It is my opinion that she/he is physically able to engage in camp activities except as noted above.

Examining Physician \_\_\_\_\_, M.D. Today's Date \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

City, State, Zip \_\_\_\_\_