

HEALTH HISTORY FORM

Day Camp Otter & Road Rangers Travel Day Camp

To be completed by Parent or Guardian

Otter Week(s) Enrolled: 1 2 3 4 5 6 7 8 9 10 11

Road Rangers Week(s) Enrolled: RR2 RR3 RR4 RR5 RR6 RR7 RR8 RR9 RR10

Camper/Staff Name: _____ Date of Birth: _____ Age at Camp: _____

Camper Home Address: _____
Street Address City State Zip

Parent(s)/Guardian(s) with legal custody to consent in case of illness or injury

Name(s): _____

Preferred Phone Number () _____ Additional Phone Number () _____

Home Address: _____
Street Address City State Zip

Additional contact in the event that the parents cannot be reached

Name: _____ Relationship to Camper: _____

Preferred Phone Number () _____ Additional Phone Number () _____

If you live outside the country, please provide information of a US contact for your child. If you are traveling while your child is at camp, please provide additional contact information in the event that you cannot be reached.

CAMPER HEALTH HISTORY

Which of the following has the participant had?

Measles Mumps Chicken Pox German Measles Hepatitis A Hepatitis B Hepatitis C

Has/does the participant:	Yes	No	Has/does the participant:	Yes	No
1. Ever been hospitalized?			12. Had fainting or dizziness?		
2. Ever had surgery?			13. Passed out/had chest pains during exercise?		
3. Have a chronic or recurring illness/condition?			14. Had mononucleosis (mono) during the past year?		
4. Had a recent illness or infectious disease?			15. Have a problem falling asleep?		
5. Had a recent injury?			16. Have problems with sleepwalking?		
6. Had asthma/wheezing/shortness of breath?			17. If female, had problems with periods/menstruation?		
7. Have diabetes?			18. Have a history of bedwetting?		
8. Ever had a seizure?			19. Have problems with diarrhea/constipation?		
9. Have frequent headaches?			20. Have any skin problems (itching, rash, acne)?		
10. Had problems with ear infections?			21. Ever had back/joint problems?		
11. Wear glasses, contacts, or prescriptive eyewear?			22. Traveled outside the country in the last 9 months?		

Please explain yes answers, noting the number of the question: _____

Camper's are expected to participate in swimming. Are you willing for your daughter to use tampons? Yes No N/A

Allergies:

Food Medication The environment (insect stings, hay fever) Other No Known Allergies

If allergic, please describe below what the camper is allergic to, the likely reaction, and how to manage it:

Diet/Nutrition*:

Camper eats a regular diet Camper eats a regular vegetarian diet Camper has special food needs (please describe below)

*Camper's must provide their own lunch and snack. This information is only used for special events and if your camper attends an overnight.

Mental, Emotional & Social Health: Check yes or no for each question.

Has the camper ever:

1. Been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)? Yes No
2. Been treated for emotional or behavioral issues (specify)? Yes No
3. Been given a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder? Yes No
4. During the past 12 months, has seen or is seeing a professional to address mental/emotional health concerns? Yes No

Please explain "yes" answers: _____

MEDICATION INFORMATION

List **ALL** medications being brought to camp. Medications **MUST** be in the original pharmacy container that identifies the name of the medication, dosage, and frequency of administration. Please include appropriate instructions for both prescription and non-prescription medications. Bring enough medication to last the entire time at camp.

Medication 1: _____

Medication 2: _____

Medication 3: _____

PHYSICIAN INFORMATION:

Name of primary care physician: _____ Phone: (____) _____

Name of dentist: _____ Phone: (____) _____

Name of orthodontist: _____ Phone: (____) _____

INSURANCE INFORMATION – MUST BE COMPLETED

The Merrimack Valley YMCA does not carry any form of accident/illness insurance on campers. Parents are responsible for medical or pharmaceutical expenses incurred at camp. You are obliged to provide the camp with the following information:

Is the participant covered by family medical/hospital insurance? Yes No

If yes, **PLEASE PROVIDE A PHOTOCOPY OF THE INSURANCE AND PRESCRIPTION CARD AND ATTACH THE COPY TO THIS FORM.**

Name of primary policy holder: _____ D.O.B. of policy holder: _____

Carrier Plan Name: _____ Group #: _____

*If you **DO NOT HAVE INSURANCE**, please sign with the understanding that you are responsible for any medical bills incurred at camp: Parent/Guardian Signature: _____ Date: _____

PARENT/GUARDIAN AUTHORIZATION FOR HEALTH CARE:

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering X-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange or provide necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above and to communicate with the primary care physician or orthodontist/dentist if necessary. This completed form may be photocopied as needed. I understand I am responsible for any medical bills not covered by insurance. Day Camp Otter, Road Rangers Travel Day Camp, and the Merrimack Valley YMCA are released herewith of any liability for any medical ministrations for any reason. **The person herein described has permission to engage in all camp activities except as noted. This health history is correct and complete as far as I know.**

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities:

CAMPER OR STAFF MEMBER SIGNATURE: _____ **DATE:** _____

MEDICAL PAPERWORK LATE FEES

All medical paperwork must be complete and received by the camp office **NO LATER THAN 2 WEEKS BEFORE YOUR CHILD START DATE AT CAMP.** **No camper will be allowed to stay at camp or participate in camp activities without a complete medical form.** Complete medical files include the Health History form, a copy of the insurance card, and the Physician's Examination form. *Late or incomplete files incur a medical late fee of \$25.*

PLEASE MAIL COMPLETED FORMS TO:

Camping Services, Camp Otter, 101 Amesbury Street; 4th Floor, Lawrence, MA 01840

PHYSICIAN'S EXAMINATION FORM
Day Camp Otter & Road Rangers Travel Day Camp
To be completed by licensed medical personnel

CAMPER'S NAME: _____ **YEAR:** _____

In accordance with requirements of the State of New Hampshire, children cannot attend a camp program without a record of health examination, completed by an approved licensed medical personal within two years of the camper's arrival at camp. **You may substitute for this form a doctor's office generic physical form and immunization record.**

Name of the Physician: _____ Tel: _____
 Address: _____

MEDICATIONS:

- This camper will not take any medications on a daily basis while attending camp
 This camper will take the following medications while at camp:

Name of Medication	Reason for Taking	When is it Given	Dosage	How is it Administered
		<input type="checkbox"/> As Needed <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		
		<input type="checkbox"/> As Needed <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		
		<input type="checkbox"/> As Needed <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		
		<input type="checkbox"/> As Needed <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other _____		

Please identify any current health problems that we need to know about:

HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PHYSICIAN

Date of last physical: _____

I attest that this child's immunizations are up-to-date: Yes No Date of last Tetanus _____
 BP _____ Height _____ Weight: _____

The above named child may participate in the full camp program without restrictions. Yes No

The above named child may participate with the following restrictions: _____

Signature of Licensed Physician: _____ **Date:** _____