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: ____

____

____

Campers 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)**

____

____

____

**Campers 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, 360 Merrimack Street; Building #9, Suite 270
Lawrence, MA 01843

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
		☐As Needed ☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other________		
		☐As Needed ☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other________		
		☐As Needed ☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other________		
		☐As Needed ☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐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:_________________