



# YMCA CAMP TIPPECANOE CAMPER HEALTH INFORMATION FORM

## PARENT/GUARDIAN INFORMATION

Camper First Name: \_\_\_\_\_ Camper Last Name: \_\_\_\_\_  
Birth Date (MM/DD/YYYY): \_\_\_\_\_ Age as of 06/01/19: \_\_\_\_\_  Male  Female  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## GENERAL HEALTH HISTORY

Check "Yes" or "No" for each statement. Please explain answers noting statement number.

Has/Does the camper:	Yes	No		Yes	No
1. Been hospitalized in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have any allergies? (list in area below) <b>If yes, please complete action plan on back.</b>	<input type="checkbox"/>	<input type="checkbox"/>
2. Had surgery in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	16. If female, have problems with periods?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have recurrent/chronic illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	17. Have problems falling asleep/sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
4. Had a recent infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
5. Had a recent injury?	<input type="checkbox"/>	<input type="checkbox"/>	19. Traveled out of country in the past 9 months?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	20. Ever been treated for ADD or ADHD?	<input type="checkbox"/>	<input type="checkbox"/>
7. Had seizures in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	21. Ever been treated for emotional/behavioral difficulties or an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
8. Had headaches in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	22. Seen a professional for mental/emotional health concerns in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
9. Had fainting/dizziness in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	23. Have an IEP? <b>(please attach a copy)</b>	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever had back or joint pain?	<input type="checkbox"/>	<input type="checkbox"/>	24. Had a significant life event? (abuse, death of a loved one, adoption, foster care, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
11. Wear glasses or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>			
12. Had asthma/wheezing/shortness of breath? <b>If yes, please complete action plan on back.</b>	<input type="checkbox"/>	<input type="checkbox"/>			
13. Passed out/had chest pain during exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
14. Had mononucleosis in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "YES" answers noting the number of the question. For #19, list countries and dates of travel.

## HEALTH CARE PROVIDERS AUTHORIZATION

Name of primary doctor(s): \_\_\_\_\_  
Phone: \_\_\_\_\_  
**REQUIRED:** The above named camper has had a physical exam within the last 12 months prior to attending camp.  
Physician's authorized signature: \_\_\_\_\_  
Date: \_\_\_\_\_

## MEDICAL INSURANCE INFORMATION

This camper is covered by family medical/hospital insurance:  
 Yes  No  
Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Subscriber: \_\_\_\_\_  
Insurance Company Phone: \_\_\_\_\_

## SIGNATURE AUTHORIZATION

The YMCA of Central Stark County and the respective branch, YMCA Camp Tippecanoe, will herein be referred to as "Camp." The camper named has permission to participate in all camp activities, except as noted by me and/or the examining physician. I agree to waive any claims against Camp for injuries or damages that may result from participation in programs. I give permission to the physician selected by Camp to provide routine health care, first aid, medication or treatment as determined by medical personnel. IN CASE OF EMERGENCY or medical care beyond the scope of camp facilities, I understand that every effort to notify listed emergency contacts will be made. I authorize Camp personnel to act on our behalf and secure emergency medical treatment and grant permission to the attending physician to secure proper treatment for the named camper. **PERMISSION TO DISTRIBUTE.** I authorize Camp personnel administer medication(s) to the named camper. understand that all prescribed medications brought to camp MUST be in the pharmacy labeled container with camper's name, dosage, health care provider's name and phone number. Camp personnel will distribute per the licensed physician's instructions. **PARENT/GUARDIAN ACKNOWLEDGEMENT:** I understand and acknowledge Camp policies and procedures outlined in the Parent Handbook, forms, and other publications. I give permission for the leadership staff of Camp to use their discretion on sharing this information with appropriate staff. I give my consent for Camp to provide transportation related to Camp activities. All information pertaining to the named camper is complete and accurate to the best of my knowledge.

Signature Authorization \_\_\_\_\_

**ATTENTION: PLEASE FILL OUT INFORMATION ABOUT YOUR CAMPER'S HEALTH ON THE BACK OF THIS FORM**