YMCA CAMP TIPPECANOE
CAMPER HEALTH INFORMATION FORM

PARENT/GUARDIANINFORMATION

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
1. Been hospitalized in the last 12 months?	☐	☐
2. Had surgery in the last 12 months?	☐	☐
3. Have recurrent/chronic illnesses?	☐	☐
4. Had a recent infectious disease?	☐	☐
5. Had a recent injury?	☐	☐
6. Have diabetes?	☐	☐
7. Had seizures in the last 12 months?	☐	☐
8. Had headaches in the last 12 months?	☐	☐
9. Had fainting/dizziness in the last 12 months?	☐	☐
10. Ever had back or joint pain?	☐	☐
11. Wear glasses or protective eye wear?	☐	☐
12. Had asthma/wheezing/shortness of breath? **If yes, please complete action plan on back.**	☐	☐
13. Passed out/had chest pain during exercise?	☐	☐
14. Had mononucleosis in the last 12 months?	☐	☐
15. Have any allergies? (list in area below) **If yes, please complete action plan on back.**	☐	☐
16. If female, have problems with periods?	☐	☐
17. Have problems falling asleep/sleepwalking?	☐	☐
18. Have problems with diarrhea/constipation?	☐	☐
19. Traveled out of country in the past 9 months?	☐	☐
20. Ever been treated for ADD or ADHD?	☐	☐
21. Ever been treated for emotional/behavioral difficulties or an eating disorder?	☐	☐
22. Seen a professional for mental/emotional health concerns in the past 12 months?	☐	☐
23. Have an IEP? **(please attach a copy)**	☐	☐
24. Had a significant life event? (abuse, death of a loved one, adoption, foster care, etc.)	☐	☐

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

CAMPER HEALTH INFORMATION

IMMUNIZATION HISTORY

My camper's immunizations required for school are up to date.
☐ YES ☐ NO Date of tetanus shot:_____

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

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

Print Name:_____

Signature:_____ Date:_____

MEDICATIONS

All prescription medication(s), dosage, and time administered must be registered with Camp Medical Staff at check-in.

This camper is currently taking prescription medication(s) and needs to continue it during his/her stay at camp: ☐ YES ☐ NO

List current medications:_____
_____

Over the counter medications are stocked in the camp health center and used on an as-needed basis to manage illness or injury.

Please list any over the counter medications NOT to be given to your camper:_____
_____

ACTION PLANS

ASTHMA ATTACK ACTION PLAN

Usual signs that an episode is occurring:
(check all that apply)

☐ Wheezing ☐ Tight Chest ☐ Cough ☐ Difficulty Breathing
☐ Difficulty Talking ☐ Other:_____

Usual signs that an episode is getting worse:
(check all that apply)
☐ Wheezing ☐ Tight Chest ☐ Cough ☐ Difficulty Breathing
☐ Difficulty Talking ☐ Other:_____

Typical triggers of an episode:
(check all that apply)
☐ Cold/flu ☐ Exercise ☐ Smoke ☐ Pollen ☐ Dust ☐ Grass/Hay
☐ Temperature ☐ Other:_____

Please list the medication, dosage, and method to treat the camper's asthmas episode:

Medication: _____
Dosage: _____ Method: _____
Medication: _____
Dosage: _____ Method: _____
Medication: _____
Dosage: _____ Method: _____

ANAPHYLAXIS EMERGENCY ACTION PLAN

Signs and symptoms that apply to the camper's anaphylactic response: (check all that apply)

☐ Itching - lips, mouth, tongue, and/or throat
☐ Hacking cough and/or repetitive cough
☐ Hoarseness of voice
☐ Hives, rash, redness, and/or irritation of skin
☐ Wheezing
☐ Vomiting and/or diarrhea
☐ Swelling - face, tongue, lips, and/or neck
☐ "Thready" pulse and/or increased heart rate
☐ Nausea and/or abdominal cramping
☐ Shortness of breath

Inject the following Epinephrine pen into thigh:
(check one)

☐ EpiPen Jr. (0.15 mg) ☐Twinject (0.15 mg)
☐ EpiPen Jr. (0.30 mg) ☐ Twinject (0.30 mg)

Doctor's Signature: _____
Date: _____
Parent/Guardian Signature: _____
Date: _____

FORMS SHOULD BE COMPLETED TWO WEEKS PRIOR TO ARRIVAL AT CAMP AND RETURNED TO THE CAMP BUSINESS OFFICE AT THE NORTH CANTON YMCA, ATTN: CAMP TIPPECANOE, 200 S MAIN ST, NORTH CANTON, OH 44720