YMCA Camp Glacier Hollow – Stevens Point Area YMCA
Resident Camp/Tripping Health History Form

FULLY COMPLETE ALL SECTIONS of this YEARLY REQUIRED Health and Care Form and return to: 1000 Division Street, Stevens Point, WI 54481 715-342-2999 Fax 715-342-2987

Camp Session Attending: _____

Participant Name _____ Birth Date _____ Age _____ ❑ M ❑ F

Street Address _____
Street City State Zip

Home Phone _____ School _____ Grade_____ Height _____ Weight_____

Parent/Guardian Name _____ **Parent/Guardian Name**_____

Home Address _____ Home Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Workplace & Ph. # _____ Workplace & Ph. # _____

Day/Cell Ph._____ Home Ph. _____ Day/Cell Ph._____ Home Ph. _____

Email _____ Email _____

Please Indicate any Custody Issues _____

Emergency Contacts (other than Parent/Guardian) and Persons Authorized to Pick Up

Emergency Contact Name _____ **Emergency Contact Name**_____

Relationship to Participant _____ Relationship to Participant _____

Day/Cell Ph._____ Home Ph. _____ Day/Cell Ph._____ Home Ph. _____

Participant's Physician _____ Phone _____
Dr. Name/Facility Office Address

Participant's Dentist _____ Phone _____
Dr. Name/Facility Office Address

Insurance Information: Is Participant covered by family medical/hospital insurance? ☐ YES ☐ NO

Carrier or Plan Name _____ Member ID# _____ Group# _____

Carrier Address & Phone # _____

Name of Insured & Birth Date _____ Relationship to Participant _____

IMMUNIZATION HISTORY: Provide the month/year for each immunization. Starred (*) immunizations must be current.
Copies of immunization forms from health-care providers or state government are acceptable, please attach to this form.

Immunization	Dose 1 month/year	Dose 2 month/year	Dose 3 month/year	Dose 4 month/year	Dose 5 month/year	Recent month/year
*Diptheria-Tetanus-Pertussis (DTP, DTaP, DT)						
*Tetanus Booster (dT) or (TdaP)						
*Measles-Mumps-Rubella (MMR)						
*Polio (IPV)						
Haemophilus Influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)			❑ Had Chicken Pox **Date:**			
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) Test Date:		❑ +pos	❑ -neg			

OVER

Participant Name _____ **Birth Date** _____ **Age** _____ ❑ M ❑ F

HEALTH CONDITIONS: (Check any that apply to the participant and explain below, include severity.)

- ❑ Sleepwalking
- ❑ Bed-wetting
- ❑ Athlete's Foot
- ❑ Warts
- ❑ Eating Disorder
- ❑ Diarrhea/Constipation
- ❑ Abnormal Menstruation
- ❑ Homesickness
- ❑ Doesn't Swim (describe)
- ❑ Nightmares
- ❑ Exercise Induced Difficulties
- ❑ Frequent Ear Infections
- ❑ Heart Defect/Disease
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Frequent Headaches
- ❑ Indigestion
- ❑ Sinus Trouble
- ❑ Frequent Nose Bleeds
- ❑ Bleeding Clotting Disorder
- ❑ Fainting/Dizziness
- ❑ Emotional/Behavior Disorder
- ❑ Skin Problems
- ❑ Joint/Bone Problems
- ❑ Head/Neck/Back Injuries
- ❑ Epilepsy/Convulsions/Seizures
- ❑ Visual Impairment/Glasses…
- ❑ Hearing Impairment/Aids…
- ❑ Speech Impairment
- ❑ Learning Disability
- ❑ ADD or ADHD
- ❑ Cognitive Disability
- ❑ Chronic Illness/Condition
- ❑ Cerebral Palsy/Motor
- ❑ Picky Eater
- ❑ Vegetarian
- ❑ Allergies
- ❑ Asthma
- ❑ Other _____
- ❑ Other _____
- ❑ Does participant have a School IEP?

Give details including triggers, signs/symptoms, care procedures and when to call parent and/or 911 for any conditions checked above: _____

_____

_____

_____

ALLERGIES: List and Describe reaction/symptoms, management instructions and when to call parent or 911.

Medications: _____

Foods: _____

Insects, Animals, Plants …_____

RESTRICTIONS or Other things we forgot to ask: List and describe any restrictions or limitations including: Recent injury/illness/infection, Dietary, Health Conditions (physical, behavioral, emotional, mental), Impairments, Other Illnesses, Major Surgeries, Special Needs and indicate if there are any adaptations that could be made: _____

_____

_____

MEDICATIONS: All Medications/Vitamins are REQUIRED to be in original containers, be clearly labeled and include written instructions. Attach additional pages as needed.

Medication Name	Dosage (tabs & mg)	Circle Time(s) to be Taken or write "PRN"(only as Needed)	Reason for Taking:
1. _____	_____	9am 1pm 4pm 7pm Bed other:____	_____
2. _____	_____	9am 1pm 4pm 7pm Bed other:____	_____
3. _____	_____	9am 1pm 4pm 7pm Bed other:____	_____
4. _____	_____	9am 1pm 4pm 7pm Bed other:____	_____
5. _____	_____	9am 1pm 4pm 7pm Bed other:____	_____

Special Instructions: _____

_____ **P/G Initials** I hereby give permission to the YMCA Staff to give participant the medications (as directed) listed above and on any additional page. I also give permission to the YMCA Staff to give the participant over-the-counter camp medications (as directed) in the event of minor pain/ailment (i.e. headache, stomach ache, sun protection, insect bites, etc…).

_____ **P/G Initials** I hereby state that the information I have provided is accurate and complete. I understand that it is my responsibility to provide any changes/updates to the YMCA. I further understand that failure to provide accurate, complete, and updated information may jeopardize participation in this program. If participant has NOT been fully immunized – I understand and accept the risks from not being fully immunized.

_____ **P/G Initials** In the event that I or emergency contact listed cannot be reached in an emergency, I give my consent for YMCA staff to act in my behalf in granting permission for participant to receive emergency treatment. I will be responsible for the payment of any and all medical services rendered. The camp has permission to obtain a copy of participant's health record from providers who treat participant and these providers may talk with the staff about participant's health status.

_____ _____ _____

Participant's Name - Please Print | Signature of Legal Parent/Guardian | Date