CAMP SLOANE YMCA

HEALTH HISTORY FORM

The Medical History is **REQUIRED FOR EACH CAMPER**. **Incomplete and/or unsigned forms are unacceptable and will prevent your child from staying at camp.**

INSTRUCTIONS:

1. **DO NOT MAIL OR FAX THIS FORM TO CAMP.** ***This form is your entrance ticket to camp and must be presented at check-in. No camper will be allowed into section without it!***
2. Complete all sections for you and your child. Please print clearly and remember to sign as parent or guardian where indicated.
3. It is acceptable to attach an immunization history and a physical exam from your physician. Note: ***The physical exam must have been completed within 24 months of the camper's last day at camp this summer***. There can be no exceptions. Medications require a doctor's signature on this form. Medication cannot be dispensed without a doctor's order and in the original prescription container.
4. Need help or have questions? Call 860/435-2557 or 800/545-9367.

SECTION 1– CAMPER & FAMILY INFORMATION

CAMPER:

Name:_____ Date of Birth_____
Last First MI

Camping Session:_____ Day Camp☐ Resident Camp☐ Age:_____ Gender: M or F

PARENT/GUARDIAN:

Name:_____ Relationship:_____

Business Phone _____ Cell Phone_____

Name:_____ Relationship:_____

Business Phone _____ Cell Phone _____

Home Address:_____
Street Apt # City ST ZIP

Home Phone _____

Name of family physician:_____ Phone _____

Name of family dentist_____ Phone _____

Name of Insured_____ Policy #_____

Carrier_____ ***PLEASE ATTACH A COPY OF YOUR INSURANCE CARD.***

Emergency Authorization

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted. **Permission to Treat**: I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me and my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. I authorize Camp Sloane to charge my credit card for all expenses incurred by Camp Sloane for the treatment of my child.

This completed form maybe photocopied for trips out of camp.

Signature of Parent/Guardian:_____ **Date:**_____

Card: Visa MC Amex Discover #_____ Exp____/____ Security #_____

HEALTH HISTORY

List any operations or serious injuries (with dates): _____

_____

List any additional health history concerns/comments: _____

_____

_____

List all allergies to **food**, **medications** and **environmental factors**: _____

_____

_____

Current or Recurring Medical Conditions:
e.g. Heart defect/disease, convulsions, diabetes, bleeding/clotting, asthma, hypertension, psychiatric treatment, ADD/ADHD, bedwetting.

_____

_____

Diseases:
_____Mumps, _____Chicken Pox,_____Measles,_____German Measles,
_____Mono,_____Whooping Cough, _____Other:_____

EMERGENCY CONTACT: An emergency contact is an adult other than a parent/guardian.

Name:_____Relationship_____

Home Phone _____Business Phone _____

Cell _____

SECTION 2-To be completed by Licensed Physician

HEALTH CARE RECOMMENDATIONS:

I have examined _____**on** _____**(Date)***p.*

Height:_____Weight:_____Blood Pressure:_____

In my opinion, the above individual **is** _____**is not**_____able to participate actively in camp programs.

If not, describe limitations:_____

_____

The applicant is under the care of a physician for the following conditions: _____

_____

_____

IMMUNIZATION RECORD

Vaccine	Month/Year	Month/Year	Month/Year	Month/Year
DTP				
TD (Tetanus/diphtheria)				
Tetanus				
Oral Polio				
MMR				
or Measles				
or Mumps				
or Rubella				
Haemophilus Influenza B				
Hepatitus B				
Varicella (Chicken Pox)				
Other				
Other				
TB Mantoux Test	Datre of Last Test:		Result (+ or -)	

Prescription Medications

Please complete with patient's current regimen for both scheduled and PRN medications.

Medication	Dosage	Quantity per Dose	Schedule	Comments:

FOR LICENSED PHYSICIAN

Signature:_____ **Date**_____

License#_____ Phone#_____

Fax#_____

Date of Physical Exam_____ By:_____

Sign if completed by nurse or physician's assistant.

CAMPER'S NAME_____ **AGE**_____

Standard Over the Counter Medications

The following medications are available at the Health Center and will be administered at the discretion of the Health Director, with parent/guardian and physician's approval. Please select which medications below can be given.

Key: PRN (if needed) PO (taken by mouth) Topical (applied to skin) Q (every)

Drug Name	Route	Dosage	Schedule and Indications	Health Provider Order	Comments
Ibuprofen (e.g. Advil, Motrin)	PO (Chew tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hours PRN Pain, fever, cold symptoms, toothache, muscle aches	YES NO	
Acetominophen (e.g. Tylenol)	PO (Chew tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hours PRN- Pain, fever, cold symptoms, toochache, muscle aches	YES NO	
Pseudoephedrine & Ibuprofen (e.g. Advil Cold and Sinus)	PO (Pills)	Per label instruction by age/weight	Q 4-6 hrs PRN Pain, fever, nasal congestion	YES NO	
Antacid (Mylanta or Tums)	PO (Pills or liquid)	Per label instruction by age/weight	Q 2-4 hrs PRN- Gas, heartburn, indigestion, stomach upset	YES NO	
Robitussin	PO (Liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN Coughs	YES NO	
Cough Drops and Lozenges	PO (Lozenges)	Per label instruction by age/weight	PRN Coughs, Sore Throats	YES NO	
Diphenhydramine (e.g. Benadryl)	PO/Topical (Pills, Liquid, Spray)	Per label instruction by age/weight	PRN- Insect bites, allergies, respiratory allergies	YES NO	
Pseudoephedrin (e.g. Sudafed)	PO (Chew tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs- Nasal/sinus congestion, hay fever, allergies	YES NO	
Ivy Block and Tecnu	Topical (Cream)	Per label instruction	Q 4 hrs PRN Contact with poison ivy	YES NO	
Calagel and Hydrocortisone	Topical (Cream)	Per label instruction	Q 6-8 hrs PRN Rash, skin irritation	YES NO	
Calamine	Topical (Cream or Gel)	Per label instruction	PRN- Insect bites, skin irritation, rash	YES NO	
Medicaine	Topical (Liquid)	Per label instruction	PRN Insect Stings	YES NO	
Antiseptics (Alcohol, Peroxide, Bacitracin)	Topical (Cream or Liquid)	Per label instruction	PRN- Stings/bites, cuts, scrapes, splinters, blisters	YES NO	
Betadine (contains Iodine)	Topical (Liquid)	Per label instruction	PRN- Cuts, scrapes, splinters, blisters	YES NO	
Antifungal Cream/ Spray	Topical (Cream or Spray)	Per label instruction	PRN- Athletes Foot	YES NO	
Cooling Gel and Aloe	Topical (Cream or Gel)	Per label instruction	PRN- Burns, sunburn, wind burn	YES NO	
Orasol, Ambesol and Abreva	Topical (Liquid or Cream)	Per label instruction	Q 6 hrs PRN- cold sores, toothache	YES NO	
Visine	Optical (Liquid)	Per label instruction	PRN- eye strain, eye irritation	YES NO	
Acetic Acid Solution	Otic (Liquid)	Per label instruction	PRN- Swimmers Ear	YES NO	
Sunscreen		Per label instruction	PRN	YES NO	
Insect Repellent		Per label instruction	PRN	YES NO	
Zyrtec	PO (pills)	Per label instruction	4-6 hrs, PRN, mild seasonal allergies	YES NO	
Claritin	PO (pils)	Per label instruction	4-6 hrs., PRN, mild seasonal allergies	YES NO	
Pink Bismuth	PO (liquid)	Per label instruction	2-4 hrs., upset stomach, diareah	YES NO	

Parent/Guardian Signature:_____ **Date**_____