YMCA Camp Wakonda
Health History & Release form

will attend camp from ___/___/___ **to** ___/___/___

Please fill out form completely and return to:
YMCA Camp Wakonda
22237 Lawrence 2080
Ash Grove, MO 65604

Cabin / Camp Date / Camper Name

First MI Last

Camper Name_____ ❑Male ❑ Female **Birthdate**___/___/___ **Age at Camp** ___

Camper Home Address_____

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name _____ **Relationship** _____ **Preferred Phone** (___)_____

Home Address: (if different) _____

Second parent/guardian or other emergency contact:

Name _____ **Relationship** _____ **Preferred Phone** (___)_____

Additional contact in event parent(s)/guardians(s) cannot be reached:

Name _____ **Relationship** _____ **Preferred Phone** (___)_____

Allergies: ❑No Known Allergies ❑This camper is allergic to: ❑Food ❑Medication ❑Environment (insect stings, hay fever, etc) ❑Other **(Please describe below what the camper is allergic to and the reaction seen.)**

Diet, Nutrition: ❑This camper eats a regular diet. ❑This camper eats a vegetarian diet. ❑This camper has special food needs. **(Please describe below)**

Restrictions: ❑ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions
❑ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. **(Please describe below)**

Medical Insurance information: This camper is covered by family/hospital insurance ❑Yes ❑No
(Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable)

Insurance Company _____ **Policy Number**_____

Subscriber_____ **Insurance Company Phone Number** (___)_____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine test, and treatment related to the health of my child for both routine health care and in emergency situation. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for and order injection, anesthesia or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of custodial Parent/Guardian_____ **Date:**_____ **Relationship to camper**_____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Are the campers immunizations up to date? ❑Yes ❑No
If your camper has not been fully immunized, please sign the following statement:
I understand and accept the risk to my child from not being fully immunized.

Camper Name_____
will attend camp from ___/___/___ **to** ___/___/___

Signature of Custodial Parent/Guardian:_____ Date:_____ Relationship to Camper_____

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.
Has/does the camper:

Ever been hospitalized?	❑Yes ❑No	Had fainting or dizziness?	❑Yes ❑No
Ever had surgery?	❑Yes ❑No	Passed out/had chest pain during exercise?	❑Yes ❑No
Have recurrent/chronic illnesses?	❑Yes ❑No	Had mononucleosis during the last 12 months?	❑Yes ❑No
Had a recent infectious disease?	❑Yes ❑No	If female, have problems with menstruation?	❑Yes ❑No
Had a recent injury?	❑Yes ❑No	Have problems with falling asleep/sleepwalking?	❑Yes ❑No
Had asthma/wheezing/shortness of breath?	❑Yes ❑No	Ever had back/joint problems?	❑Yes ❑No
Have diabetes?	❑Yes ❑No	Have a history of bedwetting?	❑Yes ❑No
Had seizures?	❑Yes ❑No	Have problems with diarrhea/constipation?	❑Yes ❑No
Had headaches?	❑Yes ❑No	Have any skin problems?	❑Yes ❑No
Wear glasses, contacts or protective eyewear?	❑Yes ❑No	Traveled outside the country in past 9 months?	❑Yes ❑No

Please explain "Yes" answers in the space below, noting the number of the question. For travel, please name countries visited and dates.

_____
_____
_____

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.
Has the camper:

Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?_____ ❑Yes ❑No
Ever been treated for emotional or behavioral difficulties or an eating disorder?_____ ❑Yes ❑No
During the last 12 months, seen a professional to address mental/emotional health concerns?_____ ❑Yes ❑No
Had a significant life event that continues to affect the campers life?_____ ❑Yes ❑No
(history of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the question. The camp may contact you for additional details.

_____
_____
_____

Medication: ❑ This camper will not take any daily medications while attending camp
❑ This camper will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. Please provide enough medication to last the entire week. All medication must be in original packaging/bottle that identifies the prescribing physician (if a prescription drug), name of medication, dosage, and frequency of administration.

Name of Medication	Reason for taking	When is given	Dosage given	How it is given
		❑Breakfast ❑Lunch ❑Dinner ❑Bedtime ❑Other_____		
		❑Breakfast ❑Lunch ❑Dinner ❑Bedtime ❑Other_____		
		❑Breakfast ❑Lunch ❑Dinner ❑Bedtime ❑Other_____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury.
*Check those the camper should **NOT** be given.*

❑Acetaminophen (Tylenol)
❑Phenylephrine decongestant (Sudafed PE)
❑Antihistamine/allergy medicine
❑Diphenhydramine antihistamine / allergy medication (Benadryl)
❑Sore throat spray
❑Lice shampoo or cream (Nix or Elimite)
❑Calamine lotion
❑Laxatives for constipation (Ex-Lax)
❑Ibuprofen (Advil, Motrin)
❑Pseudoephedrine decongestant (Sudafed)
❑Guaifenesin cough syrup (Robitussin)
❑Dextromethorphan cough syrup (Robitussin DM)
❑Generic cough drops
❑Antibiotic cream
❑Aloe
❑Bismuth subsalicylate for diarrhea (Pepto-Bismol)