

YWCA HEALTH FORM for CAMP Y-WOOD

TO BE COMPLETED BY THE PARENT or GUARDIAN

Each child must have a completed Health Form on file in the Camp Office at least two weeks before starting.

Camper's Name: _____ Gender: _____ Age: _____ DOB: _____

EMERGENCY INFORMATION:

I understand that YWCA staff is trained in the basics of first aid and CPR and I authorize them to administer such when appropriate. I also understand that the YWCA will make every effort to contact me in the event of an emergency requiring medical attention for my child. If I am unable to be reached, I authorize the YWCA to transfer my child to the nearest medical care facility.

Child's Doctor: _____ Office Number: _____

Street _____ City _____ State _____ Zip _____

EMERGENCY CONTACTS:

The YWCA will FIRST try to contact, you, the parent/guardian of the camper listed on the Enrollment Application. If you are **unable** to be reached, we have your permission to contact the following people:

1st Choice _____ Relationship: _____

Day Phone #1: _____ Day Phone #2: _____ Day Phone #3: _____

Address/City/ST/Zip: _____

2nd Choice _____ Relationship: _____

Day Phone #1: _____ Day Phone #2: _____ Day Phone #3: _____

Address/City/ST/Zip: _____

3rd Choice _____ Relationship: _____

Day Phone #1: _____ Day Phone #2: _____ Day Phone #3: _____

Address/City/ST/Zip: _____

INSURANCE INFORMATION:

The above named child is covered by health insurance: YES NO If Yes, provide the following information to expedite emergency treatment:

Policy Holder's (PH) Name: _____

Address: _____ Relation to Camper: _____

PH's Employer: _____ Work #: _____

Insurance Company Name: _____ Policy #: _____ Plan #: _____

Phone number of Insurance Company: _____

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MEDICAL INFORMATION

Physician's Name: _____ Tel: _____

Dentist's Name: _____ Tel: _____

Date of Last Health Exam: _____

Is the child *currently* under the care of a physician or psychologist?

YES NO

If YES, explain: _____

Child's Weight _____	Height: _____
Eye Color: _____	Hair Color: _____

Please complete the following if your child takes medication. Please note that medication must come to camp in its original container, clearly marked with the camper's name, date, dosage and times to be given.

Name of Medication	Used to Treat What Condition	Side Effects

Has your child experienced any of the following? If YES, please explain:

Drug Allergies:	<input type="checkbox"/> No <input type="checkbox"/> Yes:	Explain:
Food Allergies:	<input type="checkbox"/> No <input type="checkbox"/> Yes:	Explain:
Hay Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes:	Explain:
Poison Ivy, etc	<input type="checkbox"/> No <input type="checkbox"/> Yes:	Explain:
Insect Stings/Bites	<input type="checkbox"/> No <input type="checkbox"/> Yes:	Explain:
Dietary Restrictions/Needs:	<input type="checkbox"/> No <input type="checkbox"/> Yes:	Explain:
Dizziness:	<input type="checkbox"/> No <input type="checkbox"/> Yes:	Explain:
Headaches:	<input type="checkbox"/> No <input type="checkbox"/> Yes:	Explain:
Glasses, or contacts	<input type="checkbox"/> No <input type="checkbox"/> Yes:	Explain:
Frequent Ear Infections	<input type="checkbox"/> No <input type="checkbox"/> Yes:	Explain:
Bleeding/Clotting Disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes:	Explain:
Any Activity restrictions?	<input type="checkbox"/> No <input type="checkbox"/> Yes:	Explain:

Has your child been diagnosed with any of the following?

<input type="checkbox"/> Autism	<input type="checkbox"/> No <input type="checkbox"/> Yes:	
<input type="checkbox"/> ADD / ADHD	<input type="checkbox"/> No <input type="checkbox"/> Yes:	
<input type="checkbox"/> Asthma:	<input type="checkbox"/> No <input type="checkbox"/> Yes:	
<input type="checkbox"/> Diabetes:	<input type="checkbox"/> Insulin <input type="checkbox"/> Non-Insulin	
<input type="checkbox"/> Eating Disorder:	<input type="checkbox"/> No <input type="checkbox"/> Yes:	
<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> No <input type="checkbox"/> Yes:	
<input type="checkbox"/> Heart Condition	<input type="checkbox"/> No <input type="checkbox"/> Yes:	
<input type="checkbox"/> Seizures/Convulsions:	<input type="checkbox"/> No <input type="checkbox"/> Yes:	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Other Health Problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Explain

I affirm, to the best of my ability, that the information provided to the YWCA is true and valid.

Signature Parent/Guardian _____
Date