



Warner-Tully YMCA Health Form

Personal Information – Healthy History – Immunization History
Session Attending: 1 2 3 4 5 Mini

Camper's Name: _____ M or F Birthdate: _____
Father's Name: _____ Phone #'s: _____
Mother's Name: _____ Phone #'s: _____
Insurance Carrier: _____ Group # _____ Policy # _____
Emergency Contact: _____ Phone: _____

Health History

Family Physician: _____ Phone: _____
Dentist/Orthodontist: _____ Phone: _____
Currently under physician care for: _____ Current treatment: _____
Medication to be administered at camp: _____
Dietary Restrictions: _____ Food Allergies: _____

Please check any that apply:

| | | | | | |
|--------------------------------|---------------|---------------|-----------------------|----------------------|--------------|
| Frequent Ear Infections__ | Asthma__ | Chicken pox__ | Immunization History: | | |
| Insect Allergies/anaphylaxis__ | Bed Wetting__ | Seizures__ | Vacines: | Date of Immunization | Booster Date |
| Heart Defect/Disease__ | Measles__ | Poison ivy__ | D/P/T | _____ | _____ |
| Head Lice (past 4 wks)__ | Mumps__ | Diabetes__ | Polio | _____ | _____ |
| | | | MMR | _____ | _____ |

General Information and Signature

Our Healthcare Staff will make every effort to contact you if your child has need for out-of-camp health care. We do not contact you if your child is seen in the Infirmary for routine problems (skinned knees, headache etc.) that do not require a physician referral. The decision to consult you for in-camp health care is determined on a case-by-case basis by Healthcare Staff. Please attach a letter to this Health Form if you want us to follow a practice other than what is described.

My signature below releases Warner-Tully YMCA Camp, including its trustees, employees and agents from any physical injury, including death, or illness while at camp. I will assume the risk associated therewith, whether known or unknown to me at this time. This release is also intended to include all claims of my family, estate, heirs, personal representatives, or assigns.

The health information contained on this form is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted. I give Warner-Tully Camp authorization to share any health information deemed necessary with applicable camp staff that will be involved directly. I hereby give permission to the medical personnel selected by Warner-Tully Camp to order ambulance transport, order X-rays, routine tests, and treatment for the person named above. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Warner-Tully Camp to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the person named above.

Parent/Guardian Signature

Date

Physician Information

This section must be completed by a licensed physician unless a school physical can be provided that is within 2 years of camp session. Physician or Nurse MUST sign where noted.

Medical Exam by Licensed Physician - Must be completed within 24 months of Camp Attendance

Camper's Name _____ Sex _____ Birthdate _____

I have examined the above named camper on: _____
Date of Exam

In my opinion, the above camper's health status (does ___) (does not ___)
preclude his/her participation in an active camp program.

Additional Comments:

Licensed Physician's signature _____

By: _____ (please initial if completed by nurse or PA)

Phone number _____

Date Completed _____

Warner-Tully YMCA Camp
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601-638-1071
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