Warner-Tully YMCA

Health Form

Personal Information – Healthy History – Immunization History

Session Attending: 1 2 Mini 3 4 5

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__
Insect Allergies/anaphylaxis__	Bed Wetting__	Seizures__
Heart Defect/Disease__	Measles__	Poison ivy__
Head Lice (past 4 wks)__	Mumps__	Diabetes__

Immunization History:

Vacines:	Date of Immunization	Booster Date
D/P/T	_____	_____
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 of PA)

Phone number_____

Date Completed_____

Warner-Tully YMCA Camp
Vicksburg YMCA 267 YMCA Pl.
Vicksburg, MS 39183
601-638-1071 | 601-634-0918 (FAX)