YMCA Storer Camps **Adult Health Form** (18 and over)

Personal History

Name:	**Home Phone:**	**Gender:** ☐ Male ☐ Female
Street Address:	**Work Phone:**	**Date of Birth:**
City, State, Zip:	**Cell Phone and/or Pager:**	**Height:** ____ **Weight:** ____

Emergency Contact Information

Name:	**Relationship:**	**Home Phone:**	**Work Phone:**
Name:	**Relationship:**	**Home Phone:**	**Work Phone:**

Insurance Information

Please include a copy of your insurance card.

YMCA Storer Camps' does NOT carry health/accident insurance for campers, schools and conference camping participants.

Primary Policy Holder:	**Insurance Company:**	**Policy Number:**
Secondary Insurance Holder:	**Insurance Company:**	**Policy Number:**
Physician's Name:	**Physician's Phone Number:**	**Date of Last Visit:**

Medication Information

To the best of your knowledge, are you free of any communicable diseases?	☐ **Yes** ☐**No**	**If no, please explain:**
Are you allergic to any medication?	☐ **Yes** ☐**No**	**If yes, please explain:**
Are you allergic to anything else? (i.e. foods, animals, environmental allergies, etc.)	☐ **Yes** ☐**No**	**If yes, please explain:**
Are you under the care of a physician now?	☐ **Yes** ☐**No**	**If yes, please explain:**
List any medications you are presently taking:		

Date of last Tetanus Booster: ____/____/____	**Have you completed Hepatitis B Immunizations?**	☐ **Yes** ☐**No**
Date of last T. B. test: ____/____/____	**Result of T.B. test:** ☐ **Positive** ☐ **Negative**	

Do you have any physical or mental limitations, which could interfere with your activities at camp?	**☐ Yes ☐No**	**If yes, please explain:**

Communicable Disease History

Please check any that apply:

___ Chicken Pox
___ Hepatitis
___ Measles, German
___ Measles, Red
___ Mumps
___ Mononucleosis
___ Tuberculosis
___ Whooping Cough
___ Other (Specify)
_____

Other Health Issues

Please check any that apply:

___ Asthma
___ Bleeding Disorders
___ Diabetes
___ Ear Aches
___ Eating Disorders
___ Emotional Concerns
___ Frequent Colds
___ Headaches
___ Hearing Difficulties
___ Heart Condition
___ Hypertension
___ Migraine Headaches
___ Seizures
___ Sight Difficulties
___ Sinus Infections
___ Skin Conditions
___ Urinary Tract
___ Other _____

Explanation of Treatment of Above: _____
_____
_____

State recent operations, illnesses and/or injuries: _____
_____
_____

Authorization

(This section must be signed and is required under Michigan State laws, unless there is religious objection.) "This Camp Health Information is correct so far as I know and I am able to engage in all camp activities, except as specified. I hereby give my permission to _____ to secure emergency medical and surgical treatment and to provide routine medical care for me while at camp."

_____ _____
Signature Date