

YMCA STORER CAMPS: SUMMER CAMP YOUTH HEALTH FORM

Personal Information

Camper's LAST Name (Printed)	Camper's FIRST Name (Printed)	Date of Birth (Month, Day, Year)
Home Address	Height:	Weight:
	Camp Arrival Date:	
	Camp Departure Date:	
Village: <input type="checkbox"/> Adventurer (age 7-8) <input type="checkbox"/> Ranger (age 8-9) <input type="checkbox"/> Pioneer (age 10-11) <input type="checkbox"/> Explorer (age 12) <input type="checkbox"/> Trailblazer (age 13-16) <input type="checkbox"/> LIT (age 15-16) <input type="checkbox"/> CIT (age 16-17) <input type="checkbox"/> Ranch (age 12-17) <input type="checkbox"/> Pathfinder/Outback (age 13-16) <input type="checkbox"/> Day Camp (age 5-10)		

Emergency Contact Information

Parent/Guardian Name (<i>Primary Contact</i>)	Relationship to Camper	Phone Number	Work Phone Number
Parent/Guardian Name (<i>Secondary Contact</i>)	Relationship to Camper	Phone Number	Work Phone Number
Alternate Contact Name	Relationship to Camper	Phone Number	Work Phone Number
Alternate Contact Name	Relationship to Camper	Phone Number	Work Phone Number

Insurance Information

YMCA Storer Camps does not carry health/accident insurance for campers, schools or conference camping groups. In the case that your child needs advanced medical care, **please attach a copy of your insurance card, front and back sides, to this form.**

Primary Policy Holder	Relationship to Child	Insurance Company	Policy Number
Physician's Name	Physician's Phone Number	Date of Last Doctor's Visit	

Parent/Guardian Authorization

The information contained in this form is correct, as far as I know, and the child herein described has permission to engage in all camp activities except as noted. I understand that health/accident insurance coverage is the responsibility of the parent/guardian. I hereby give permission to YMCA Storer Camps to secure emergency medical, routine medical, surgical treatment, and non-surgical care for the child named on this form, while at camp. I also understand that the parent/guardian is fully responsible for the camper's transportation if he/she is dismissed for disciplinary, behavior or medical reasons. I absolve the YMCA of Greater Toledo/Storer Camps and all of its employees of any and all liability, financial and/or otherwise arising from administration of medication to my child under the terms of this release. YMCA Storer Camps is not responsible for payment of any medical expenses incurred during participation at camp.

In consideration for being allowed to participate in the YMCA's programs, I agree to assume the risk of such activities and programs, and I further agree to hold harmless the YMCA of Greater Toledo, its officers, employees and representatives from any and all claims, suits, losses, or related causes of action for damages, including, but not limited to, such claims that may result from injury or death, accident or otherwise, during or arising in any way from the activities. I grant permission for me or my child to participate in all planned camp activities including out of camp trips by van or bus, hiking or horseback riding. The YMCA is not responsible for lost, stolen or damaged personal articles. I also authorize the YMCA to have and use photographs, slides or video tapes of me, my child, or my family as may be needed for its public relations programs. I acknowledge that this General Release of Liability and Authorization for Treatment of the YMCA is binding on me personally and on my heirs, personal representatives, successors and assigns.

Limited Purpose Power of Attorney: Consent to Treatment of Minor (Must be signed by parents or legal guardians)

By signature(s) below, the undersigned appoints YMCA Storer Camps to act alone, or delegate to another person, the power to consent on our behalf to all emergency treatment and/or medical care (except elective surgery) of (child's name) _____ determined to be necessary or desirable by our child's attending physician at the hospital. This Power of Attorney shall continue through the participant's stay at camp, or until revoked by the undersigned, whichever is earlier. Physicians or the hospital's medical staff may assume and rely on this authorization being current and in effect during such period unless notified otherwise. The undersigned certify that they read this Power of Attorney (or had it read to them), that they understand this Power of Attorney, and sign it voluntarily. This agreement will be enforced in accordance with the law of the State of Michigan.

Parent/Guardian Signature: _____ **Date:** _____

Camper Name: _____ Village: _____ Arrival Date: _____

Medication Permission

Our Health Center is stocked with medications used to manage illness and injury as directed by our medical protocols. A list of our stocked medications can be found at: <http://www.ymcastorercamps.org/who-we-are/download-resources/>
Please list any medications that your camper should **NOT** be given:

Medication Information

“Medication” is ANY substance used to maintain and/or improve an individual’s health, including vitamins and supplements.

Per Michigan state law, medications must meet the following standards:
Medication must arrive in its original packaging. Medication will only be administered in age-appropriate doses according to the medication label or a signed physician’s note. Medication cannot be expired, per the expiration date on the medication container.

- Please note:*
- Campers are expected to carry their emergency medications (epinephrine injectors, rescue inhalers and diabetic supplies) on their person, while at camp. All other medications, vitamins and supplements must be stored at our Health Center.
 - Our Health Center is stocked to manage illness and injury as directed by our medical protocols. Campers do not need to bring their personal Tylenol, Ibuprofen, Benadryl, Tums, Sudafed, Cough Drops, Hydrocortisone Cream or Antibiotic Ointment to camp.

Please list all medications your camper will be bringing to camp.

MEDICATION NAME AND STRENGTH	REASON FOR TAKING	MEDICATION DOSE	WHEN GIVEN	YEAR STARTED
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Other: _____ <input type="checkbox"/> Dinner <input type="checkbox"/> Only As Needed <input type="checkbox"/> Bedtime	
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Other: _____ <input type="checkbox"/> Dinner <input type="checkbox"/> Only As Needed <input type="checkbox"/> Bedtime	
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Other: _____ <input type="checkbox"/> Dinner <input type="checkbox"/> Only As Needed <input type="checkbox"/> Bedtime	
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Other: _____ <input type="checkbox"/> Dinner <input type="checkbox"/> Only As Needed <input type="checkbox"/> Bedtime	
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Other: _____ <input type="checkbox"/> Dinner <input type="checkbox"/> Only As Needed <input type="checkbox"/> Bedtime	
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Other: _____ <input type="checkbox"/> Dinner <input type="checkbox"/> Only As Needed <input type="checkbox"/> Bedtime	

If your camper takes additional medication, please list the medication, dosage and time given and attach to this health form.

Immunizations

Starred (★) immunizations *MUST* be current. **Please attach a copy of your child’s immunization records to this form.**

Immunization	MMR (measles, mups, rubella)★	DTap (diphtheria, tetanus, pertussis)★	IPV (polio)★
Date: Month(s) & Year(s)			

Camper Name: _____ Village: _____ Arrival Date: _____

Nutrition

<input type="checkbox"/> This camper has no dietary restrictions. This camper has the following dietary restrictions: <input type="checkbox"/> No beef <input type="checkbox"/> No pork <input type="checkbox"/> Vegetarian (no meats or seafood) <input type="checkbox"/> Vegan (no meats, seafood, eggs or dairy) <input type="checkbox"/> Gluten-intolerant <input type="checkbox"/> Lactose intolerant	Please provide additional dietary information, if necessary: Our kitchen prepares well-balanced meals. We work with dietary concerns but do not cater to individual food preferences. Please call us at 517-536-8607 if you have questions pertaining to your camper's dietary needs.
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Allergies

This camper has: No Known Allergies Seasonal Allergies Food Allergies Medication Allergies Other Allergies

Please list what your camper is allergic to, their reaction and how it is treated:

Do any of the above cause an anaphylactic (life-threatening) reaction?

No Yes: if Ingested★ Yes: if Touched★ Yes: if Airborne★

★If yes, please complete our additional Anaphylaxis Form and attach it to this health form. It can be found on our website at <http://www.ymcastorerccamps.org/who-we-are/download-resources/>

Health History

★ If your child has Asthma and/or Diabetes, please complete an Asthma and/or Diabetes Form and attach it to this health form. These forms can be found on our website at <http://www.ymcastorerccamps.org/who-we-are/download-resources/>

Please check any of the following that pertain to your camper:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Asthma ★ | <input type="checkbox"/> Diarrhea and/or Constipation | <input type="checkbox"/> Menstruation Issues | <input type="checkbox"/> Vision Concern |
| <input type="checkbox"/> Diabetes ★ | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Migraines | <input type="checkbox"/> Recent Illness and/or Injury |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mobility Concern | <input type="checkbox"/> Recent Surgery |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Recent Hospitalization |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Sleepwalking | |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Skin Issues | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Homesickness | <input type="checkbox"/> Traveled Outside United States (within the last year) | |
| <input type="checkbox"/> Chronic Pain/Injury | <input type="checkbox"/> Mental Health Concern | <input type="checkbox"/> None of the Above | |

Please give details about checked items and note if your camper has any activity restrictions due to their health history. If you would like to discuss a special concern with our Summer Programs Director, please call 517-536-8607.

Camper Name: _____ Village: _____ Arrival Date: _____

Camper Information

We at YMCA Storer Camps want your camper to have the best experience possible. To help with this effort, please give any information you would like to be shared with your child's camp counselors.

About my camper:

What techniques are most successful for your child in the case of behavior management and/or conflict?

Does your camper:	Additional Details
Adjust well to change <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Yes	
Socialize easily with their peers <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Yes	
Become easily frustrated <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Yes	
Take directions well <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Yes	
Have a positive mental outlook <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Yes	

MEDICAL CONCERNS

Please provide tips and/or details that you would like to be shared with your child's camp counselors. All special concerns are CONFIDENTIAL.

- History of Bedwetting:
- History of Sleepwalking:
- History of Night Terrors:
- History of Seizures:
- Diabetic/Hypoglycemic:
- Allergies:
 - Has epinephrine injector (EpiPen, Auvi-Q, etc.)
- Asthma:
 - Has rescue inhaler (Albuterol, Pro Air, Ventolin, etc.)
- Other: