YMCA STORER CAMPS ~ OEE YOUTH HEALTH FORM

Personal Information

Student's Last Name (Printed)			Student's First Name (Printed)		M.I.
Street Address			Date of Birth (Month, Day, Year)		Age
			School		Gender ☐ Male ☐ Female
City	State	Zip	Height	Weight	

Emergency Contact Information

We will certainly call in an emergency, but we'll also call if we have questions about your camper's health.

Father/Guardian Name	Father/Guardian Home Phone	Father/Guardian Work Phone	Father/Guardian Cell/Pager
Mother/Guardian Name	Mother/Guardian Home Phone	Mother/Guardian Work Phone	Mother/Guardian Cell/Pager
Emergency Contact Name	Emergency Contact Phone	Relationship to Child	Emergency Contact Cell/Pager

If we cannot reach you or your emergency contact, please provide contact information for other people who know your camper and with whom we can consult. We assume you have spoken to these contacts and they are willing to assist should the need arise.

Alternate Contact _____ Phone: _____ Relationship: _____

Alternate Contact _____ Phone: _____ Relationship: _____

Medication Information

Please list any additional medications on a separate sheet and attach to your health form.

"Medication" is any substance a person takes to maintain and/or improve his/her health. Includes vitamins and homeopathic remedies.

☐ This student will not take any daily medication while attending YMCA Storer Camps.

☐ This student will take the following daily medication(s) while attending YMCA Storer Camps. Bring enough of each medication to last their entire stay. ALL medications must arrive in appropriately labeled pharmacy containers as described in the "Health Services Parent Information".

NAME OF MEDICATION	REASON FOR TAKING IT	WHEN GIVEN AND DOSAGE	DATE STARTED
		☐ Breakfast Dose: _____ ☐ Lunch Dose:_____ ☐ Dinner Dose: _____ ☐ Bedtime Dose: _____ ☐ Other: _____	
		☐ Breakfast Dose: _____ ☐ Lunch Dose:_____ ☐ Dinner Dose: _____ ☐ Bedtime Dose: _____ ☐ Other: _____	
		☐ Breakfast Dose: _____ ☐ Lunch Dose:_____ ☐ Dinner Dose: _____ ☐ Bedtime Dose: _____ ☐ Other: _____	

We have many over the counter medications stocked in our Health Centers used to manage illness and injury as directed by our medical protocols. Please list any over the counter medications that your student should **NOT** be given.

_____

_____

Student Name:_____ School:_____

Insurance Information

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

Immunizations

All my student's immunizations are up to date. ☐ Yes ☐ No

Date of last Tetanus Booster: Month/Year_____

Allergies

❑ This student has no known allergies.

❑ Is allergic to this food(s): _____
_____

Causes anaphylaxis? ☐ No ☐ Yes: Ingestion★
☐ Yes: Contact★ ☐ Yes: Airborne★

Describe their reaction and how it is managed:
_____
_____
_____

❑ Is allergic to this medication: _____
❑

Causes anaphylaxis? ☐ No ☐ Yes★

Describe their reaction and how it is managed:
_____
_____
_____

❑ Is allergic to the following: _____
❑

Causes anaphylaxis? ☐ No ☐ Yes★

Describe the reaction and how it is managed:
_____
_____
_____

Nutrition

Our kitchen prepares well-balanced meals. We can work with some medically prescribed diets but do not cater to individual food preferences.

❑ This student eats a regular diet.

❑ This student has the following type of diet.

- ☐ Semi-vegetarian (no pork or beef)
- ☐ Pesco (no pork, beef or chicken)
- ☐ Lacto-ovo (no pork, beef, chicken, seafood or fish)
- ☐ Vegan (no meats, seafood, eggs or dairy)

❑ This student does not eat pork because of faith reasons.

❑ This student is gluten-intolerant.

❑ This student is lactose-intolerant.

Please provide any additional information if necessary:
_____
_____
_____

Please call us at 517-536-8607 if you have questions pertaining to your student's dietary needs.

Health History

Please check those that pertain to your camper and describe how it is handled at home.

❑ My camper is free from illness, injury, physical challenges or health concerns that would affect participation in programming.

★Asthma, Diabetes or Anaphylaxis
Please complete the additional "Request for Information" forms and attach to this Health Form. Forms can be downloaded from our website: www.ymcastorercamps.org

The following is **TRUE** for my camper:

- ☐ Anaphylaxis ★
- ☐ Asthma ★
- ☐ Diabetes ★
- ☐ ADD/ADHD
- ☐ Autism
- ☐ Bedwetting
- ☐ Bleeding/Clotting
- ☐ Chronic Illness
- ☐ Diarrhea/Constipation
- ☐ Eating Disorder
- ☐ Emotional Health Concern
- ☐ Fainting
- ☐ Frequent Colds
- ☐ Frequent Ear Infection
- ☐ Frequent Headaches
- ☐ Has Glasses/Contacts
- ☐ Had Chicken Pox/Varicella Immunization
- ☐ Hearing Impairment
- ☐ Head Injury
- ☐ Heart Defect/Disease
- ☐ Homesickness
- ☐ Psychiatric Treatment/Counseling
- ☐ Seizure Disorder
- ☐ Sleepwalking
- ☐ Skin Problems
- ☐ Surgical History of Consequence
- ☐ GIRLS ONLY: Knows about menstruation and/or has regular menstrual history
- ☐ GIRLS ONLY: Menstrual cramps
- ☐ Recent Illness:_____
- ☐ Recent Injury:_____
- ☐ Recent Hospitalization:_____
- ☐ Recent Surgery:_____
- ☐ Other (specify):_____

Please give more information about checked items above. Attach additional information if needed:

If your student has had a significant life event that continues to affect the student's life, please provide information about the event, its impact upon your student's life and care tips for their time at camp. Attach additional information if needed.

Student Name:_____ School:_____

What Else Would You Like Us To Know? Let us know any information about your camper's health that may have been neglected on this form. Any information that has an impact on your student's ability to fully participate in our program is appreciated. Attach additional information if needed.

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, it's 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_____ (School Name), 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:** _____

Health Office Use Only

Date	Time	CHO	Notes