



Health Information Form



Consent:

I hereby give my consent, in the event of a medical emergency when I cannot be contacted, for YMCA and Camden Parks and Recreation staff to obtain whatever treatment may be deemed necessary for:

Camper Name #1: _____ Birthdate: _____ | _____ | _____

Street | P.O. Box: _____

Town | State: _____ Zip: _____

This authorization includes my consent for the above-named child to receive treatment by a physician in any hospital emergency department. I hereby give my authorization for emergency medical treatment as outlined above.

(PRINT) Parent or Guardian Name

(SIGNATURE) Parent or Guardian

Name of Child's Physician: _____ Phone: _____

Street Address:: _____

Town | State: _____ Zip: _____

Health Insurance Carrier: _____ ID#: _____ Group #: _____

Date of last tetanus shot: _____

Does your child self-administer any medications, such as an inhaler or Epi-Pen? Please list any medication your child will/could self-administer at camp. All medication must be given to the camp director and must come in original bottle with child's name, medication, dosage and doctor.

No: ___ Yes (please list): _____

Please list any medication your child will need to take during camp. All medication must be given to the camp director and must come in original bottle with child's name, medication, dosage and doctor.

Camper Medical History (please check all that apply)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other _____ |

Allergies (please check all that apply)

- | | | | |
|-------------------------------------|--|---------------------------------------|---|
| <input type="checkbox"/> Animals | <input type="checkbox"/> Serious Ivy, Oak, Sumac | <input type="checkbox"/> Insect Bites | <input type="checkbox"/> Bee/Wasp/Hornet Stings |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Foods _____ | <input type="checkbox"/> Medications | <input type="checkbox"/> Other _____ |

