FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CAMP ULBRICH

WALLINGFORD FAMILY YMCA
81 S Elm Street, Wallingford CT 06492
P 203-269-4497 **F** 203-284-0572

YOUTH CAMP HEALTH EXAM/RECORD

TO BE COMPLETED BY PARENT OR GUARDIAN

CAMPER NAME ______________________ BIRTHDATE ______________________

PARENT/GUARDIAN ______________________ PHONE ______________________

ADDRESS ______________________ CITY/ST/ZIP ______________________

EMERGENCY CONTACT ______________________ PHONE ______________________

HEALTH HISTORY

(CHECK & GIVE APPROXIMATE DATES)

- ○ CHICKEN POX ______________________
- ○ WHOOPING COUGH ______________________
- ○ MEASLES ______________________
- ○ MUMPS ______________________
- ○ OTHER ______________________

OPERATIONS, INJURIES & RESTRICTIONS

(EXPLAIN & GIVE APPROXIMATE DATES)

____

____

____

____

____

____

ALLERGIES

(CHECK & GIVE ADDITIONAL DETAILS)

- ○ HAY FEVER ______________________
- ○ ASTHMA ______________________
- ○ PLANTS ______________________
- ○ MEDICATION ______________________
- ○ INSECTS ______________________
- ○ FOOD ______________________
- ○ OTHER ______________________

MEDICATIONS BEING TAKEN

(NAME & EXPLAIN)

____

____

____

*****IF MEDICATIONS ARE TO BE TAKEN AT CAMP, WE MUST HAVE MEDICATION ADMINISTRATION FORMS ON FILE BY JUNE 15*****

AUTHORIZATION FOR SUNSCREEN ADMINISTRATION BY CAMP STAFF

(IF NECESSARY)

I hereby request that **sunscreen** be administered to my child by a YMCA staff member at Camp Ulbrich while they are enrolled in camp. The sunscreen will be administered to any exposed skin as needed for sun protection, and reapplied after extended sun exposure or swimming. I understand that that I must supply the sunscreen in the original container labeled with my child's name. By signing below, I affirm that I have administered the sunscreen provided to my child without adverse side effects.

____

PARENT/GUARDIAN SIGNATURE DATE

CAMP STAFF USE

PARENT OR GUARDIAN MEDICAL AUTHORIZATION

(REQUIRED FOR ALL PERSONS UNDER THE AGE OF 18)

By signing below, I attest that this health history is correct so far as I know, and my child named previously has permission to participate in all camp activities except as noted by me or the physician. If I cannot be reached in an emergency, I hereby give permission for the YMCA staff and/or physician selected by the Camp Director to hospitalize, secure medical treatment for and order injection, anesthesia or surgery for my child as named previously.

____

PARENT/GUARDIAN SIGNATURE DATE

CAMP ULBRICH

WALLINGFORD FAMILY YMCA
81 S Elm Street, Wallingford CT 06492
P 203-269-4497 **F** 203-284-0572

YOUTH CAMP HEALTH EXAM/RECORD

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER

CAMPER NAME ______________________________ **BIRTHDATE** ______________

DATE OF EXAM _____/_____/________

_______ **May participate in all camp activities**

_______ **May participate except for** ____

____

Medical information pertinent to routine care and emergencies

____

____

Is **this individual taking prescription or over the counter medication(s)?** ○ YES ○ NO

If yes, indicate names of medication(s):__________________________________

Does the individual have allergies? ○ YES ○ NO

If yes, explain: ____

Is the individual on a special diet? ○ YES ○ NO

If yes, explain: ____

Does the individual have special needs? ○ YES ○ NO

If yes, explain: ____

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

Measles	○ YES	○ NO	Hepatitis B	○ YES	○ NO
Mumps	○ YES	○ NO	Diptheria	○ YES	○ NO
Rubella	○ YES	○ NO	Pertussis	○ YES	○ NO
Chicken Pox	○ YES	○ NO	Polio	○ YES	○ NO
Pneumococcal conjugate	○ YES	○ NO	Tetanus	○ YES	○ NO

Comments

____

____

____

____
SIGNATURE OF PHYSICIAN, PA, APRN OR RN **DATE**

MEDICAL CARE PROVIDER INFORMATION

NAME ______________________________ **PHONE** ______________________

ADDRESS ______________________________ **CITY/ST/ZIP** ______________________