YMCA Camp Hi-Rock Medical Form

Enter session(s) # Day Camp:______ Resident Camp:_______

Parent or Guardian, please complete front page. Return no later than two weeks before camper arrives.

Camper Name:________________________________ Date of Birth:________________ Age:________ Gender:________

Home Address:__________________________________ City:_______________________ State:_____ Zip:___________

Mother/Guardian's Name:___________________________ Father/Guardian's Name:______________________________

Address:____ Address:____

City:_____________________ State:______ Zip:________ City:________________ State:_______ Zip:______________

Home Phone:(_____)________________________________ Home Phone:(_____)_________________________________

Work Phone:(_____)________________________________ Work Phone:(_____)_________________________________

Name of Emergency Contact other than parent/guardian listed above:____

Home Phone:(_____)________________________________ Work Phone:(_____)_________________________________

Please keep camp informed of other address and phone numbers where you can be reached if you will be traveling while you child is at camp.

Camper's Primary Care Physician's Name:_________________________________ Phone:(_____)__________________

Address:__________________________________ City:_________________________ State:_______ Zip:____________

Date of camper's most recent physical examination:___________________

Name of Family Dentist/Orthodontist:_____________________________________ Phone:(_____)__________________

MEDICAL INSURANCE INFORMATION

IF YOU HAVE A CARD OR FORM PLEASE PROVIDE A COPY

Subscriber Name		Social Security #	
Carrier Name		Carrier Address	
Group Name		Group Number	

Does your insurance require notification prior to emergency care or appointment with non primary care physician? _______

Has your camper ever required psychiatric counseling? Explain: ____

Dates of operations and serious illnesses:____

Disability or chronic or recurring illness:____

Activities encouraged or limited by a physician:____

Dietary Modifications:____

Current Medications (YOU MUST COMPLETE THE MEDICATION ADMINISTRATION RELEASE FORM):____________

____

Please list other diseases, allergies to medication or health information you wish our health care provider to know:

____

Please read, understand, and sign the following release, indemnity, and authorization for treatment.

I consent to the aforementioned camper participating in any YMCA Camp Hi-Rock programs or activities, either on or off camp property. I acknowledge that participation in camp activities has inherent risk. I, the undersigned parent or guardian, assume that risk on behalf of my child and will indemnify and hold harmless the camp/Central Connecticut Coast YMCA from and against all claims and demands on account of, or in any way from, any accidental occurrence. In the event that my child should need further medical treatment while at camp, I give the camp medical staff permission to order x-rays, routine tests, treatments that may require hospitalization, and necessary transportation. I give the camp medical staff permission to administer medication or treatment prescribed by the camp's local physician should this become necessary. I understand that the camp medical staff may be unable to contact me at the time when medical treatment is necessary and therefore grant permission for them to seek and administer such treatment and medication prior to contacting me for further permission. I authorize payment of medical benefits to the health care provider for any necessary services and the release of any medical or other information necessary to process claims for visits incurred. In addition, I give the camp medical staff permission to administer other over-the-counter medications they deem necessary. I confirm that, to the best of my knowledge, my child is not allergic to any medications other than those listed above. I further grant any pictures taken of my child at camp to be used for publicity and promotional purposes. This completed form may be photocopied. I have read the above and understand its meaning.

Printed name of Parent/Guardian ____

Signature of Parent/Guardian: ____ Date: ___________

Witness:____ Date: ___________

Name: ____

Medical History: To be completed by a Physician. A Certificate of Immunization is to be attached. This form must be fully completed before sending to camp. This is the only form approved by the local Board of Health. It meets local regulation requirements.

* = Required for campers and staff under 18 years old ** = Required for both staff and campers

Immunizations	Dates	Immunizations	Dates	Immunizations	Dates	Special	Dates
Polio Vaccine* (TOPV) or (e-IPV)		MMR** (combined) Measles, Mumps, and Rubella		Adult Type Toxoid** (Td) Tetanus/Diphtheria (if more than ten years have elapsed since last dose)		Tuberculin Screen**	
Hepatitis B* (if born after 1/1/92)		DTP** Diphtheria, Tetanus, and Pertussis		Other:		Other:	

Please indicate the medical conditions below that your child has experienced and give approximate dates.

	Date		Date		Date		Date
Accidents		Ear Infections		Measles		Rubella	
Allergies		Encephalitis		Meningitis		Scarlet Fever	
Bleeding Disorder		German Measles		Mononucleosis		Scoliosis	
Chicken Pox		Heart Disease/Defect		Mumps		Strep Throat	
Congenital Anomaly		Hernia		Operations		Tonsilitis	
Convulsions		Hypertension		Poliomyelitis		Tuberculosis	
Diabetes		Kidney Disease		Rheumatic Fever		Whooping Cough	

Please list any allergies including reaction and treatment:(drugs, food, environment, poison ivy, insect stings, other):

____

Please specify any dietary restrictions:____

Current Medications (YOU MUST COMPLETE THE MEDICATION ADMINISTRATION RELEASE FORM):_____________

____

Other medical conditions that may effect the camper's activities while at camp:____________________

____

Physician's Examination: Age:_____ Blood Pressure:______/_____ Pulse:______ Height:_________ Weight:________

Physical Development:____

I have completed the above and have examined the individual. In my opinion, the condition of the person listed above does not preclude his/her participation in an active camp program. I have screened the individual for signs of active tuberculosis.

Licensed Physician's Signature:____

Address:____ Phone:(_____)_________________

Date of form completion:_____________ By (initial if completed by nurse or physician's assistant):____________________

Date examined by camp nurse:_________________________ Initials:_____________ Cabin:___________________

Please Note: According to Commonwealth of Massachusetts Law, we may not admit any child to camp without this completed medical form. The front page must be completed by the camper's parent/guardian including the signed authorization for treatment. This side must be completed by a physician. The camper must have been examined by a physician within 24 months year prior to his/her stay at camp. All campers must have a record of immunizations meeting the Massachusetts immunization requirements for children attending recreational camps. For more information please contact your physician or the camp office.