



SESSION(s): _____

YMCA OF METROPOLITAN MILWAUKEE
2012 CAMP HEALTH EXAMINATION FORM

This form MUST BE RETURNED BY JUNE 1 to the Camp Office

Section 1 – 3 to be filled out by parent/guardian and section 4 to be filled out by your child’s physician. All highlighted areas must be signed and a copy of your health insurance card must be included when returning this form. Camp reserves the right to deny admission to camp without proper signatures and forms.

SECTION 1

CAMPER’S PERSONAL INFORMATION

First Name _____ Middle _____ Last _____ Boy _____ Girl _____
Birthday ____/____/____ Age on first day of session ____ Home Phone (____) _____

GUARDIAN INFORMATION

1st Parent/Guardian First _____ Middle _____ Last _____ Relationship _____
E-Mail _____ Cell Phone (____) _____
Address _____ Work Phone (____) _____ Ext. _____
City, State, Zip _____
2nd Parent/Guardian First _____ Middle _____ Last _____ Relationship _____
E-Mail _____ Cell Phone (____) _____
Address _____ Work Phone (____) _____ Ext. _____
City, State, Zip _____
Custodial Parent (camper lives with...) Parent 1 Parent 2 Both Other _____

EMERGENCY CONTACTS/OTHERS ALLOWED TO PICK UP YOUR CHILD (If parent/guardians listed above are not available)

Name	Relationship	Daytime Phone	Night Phone
_____	_____	_____	_____
_____	_____	_____	_____

HEALTH INSURANCE COMPANY INFORMATION *Must include a photocopy of both sides of insurance card*

Insurance Company _____ Group and/or Policy Number _____
Policy Holder’s Name _____ Policy Holder’s Birth date ____/____/____

- Select One: This child takes no medications on a routine basis.
 A health form addendum accompanies this form detailing this child’s medications and dosing schedule. (Please turn in the Addendum when you bring your child to camp with the medication.)

SECTION 2

PARENT’S MEDICAL AUTHORIZATION AND GENERAL PARTICIPATION AGREEMENT:

By signing, the parent/guardian certifies approval of good health of the camper, and in the event that I cannot be reached in an emergency, authorize the YMCA health care staff/volunteers to render first aid; give permission to the physician selected by the YMCA of Metropolitan Milwaukee to hospitalize, secure proper treatment for and to order injections, anesthesia or surgery for my child as named above. I give permission to camp health officer/doctor to dispense over-the-counter products (Tylenol, cough syrup, etc.) and prescriptions as needed. Prudent attempts will be made to contact parents regarding health care issues. I agree to release the YMCA of Metropolitan Milwaukee from any liability for the risk of illness, accidents or injury. I agree to pay the balance of the camp fees no later than June 1 and understand the YMCA cannot hold reserved space beyond that date without full payment. If my camp fees are not paid in full two weeks before the start of the session then I authorize the YMCA to charge my credit card on file the remainder of the camp fees, I understand that all late payments will result in a \$50 late fee if a payment plan is not set up for my account. Camp fees are not refundable without a doctor’s authorized medical reason. I understand that no refunds are given if a child leaves early because of homesickness or disruptive behavior as determined by the Camp Director. The deposit is not refundable or transferable under any circumstances. I grant permission for the applicant to participate in all planned camp activities including participation in high adventure elements, swimming, canoeing, hiking, skateboarding or horseback riding. The YMCA is not responsible for lost, stolen or damaged articles. I also authorize the YMCA to have and use photographs, slides and videotapes of the person named in this application as may be needed for its public relations and social media programs. I give permission for the child named to attend traveling field trips supervised by the YMCA staff members at all times, to and from camp by van, hired bus company, by foot, by bike or by horseback as it pertains to their chosen activities. I agree to waive claims against the YMCA and its members and volunteers to injuries or damages that may result from the conduct of other persons including participants in YMCA programs.

Parent/Guardian Signature: _____ Date: _____

Last Name _____
First Name _____
Session _____

Camper's First Name _____ Last Name _____

SECTION 3

HEALTH HISTORY

Check all that apply and give dates. *For * items, a health form addendum must be completed and returned. For ** items, please make sure to note on Parent/Counselor form.*

ALLERGIES*	DISEASES	OTHER
Hay Fever _____	Chicken Pox _____	Ear Infections _____
Ivy Poisonings _____	Measles _____	Rheumatic Fever _____
Insect Stings* _____	German Measles _____	Seizures _____
Penicillin _____	Mumps _____	Skin Conditions _____
Other Drugs _____	Asthma* _____	Behavioral Issues** _____
Food* _____	Diabetes* _____	Special Needs** _____

Any specific activities to be restricted _____

Operations or Serious Injuries (dates) _____

Chronic or Recurring Illness* _____

Other Diseases or Details of Above _____

Please notify camp if this camper is exposed to any communicable disease during the three weeks prior to camp.

IMMUNIZATION HISTORY

Please record the dates and immunizations with most recent booster doses. This information is required for camp attendance. *(If you would prefer you can attach a copy of your child's immunization records)*

DTP Series _____ booster _____	Tetanus Booster _____
Polio OPV (sabin) _____ booster _____	Typhoid _____
Measles Vaccine (live) _____	Tuberculin Test _____
German Measles (Rubella) _____	Mumps Vaccine (live) _____
Smallpox _____	Varicella Vaccine (chickenpox) _____
Other/Additional Immunizations _____	

SECTION 4

***** For Overnight Campers Only *****

MEDICAL EXAMINATION: To be filled out by licensed physician. This **examination must be performed within 24 months of arrival** at camp. Examination for some other purpose within this period of time is acceptable. Examination is for determining fitness to engage in strenuous activities. If we should have a signature on file from last year, please indicate that in the highlighted section below.

Date of Exam: _____ Height _____ Weight _____ B.P. _____

(Please indicate yes for satisfactory and no if there are any concerns. Please include explanations of negative responses)

Eyes _____	Extremities _____
Glasses _____	Posture (Spine) _____
Ears _____	Skin _____
Nose _____	Abdomen _____
Lungs _____	Allergy: _____
Throat _____	Please Specify _____
Teeth _____	Heart _____

General Appraisal: _____

(For Girls and Women)

Has this person menstruated? ____ If not, has she been told about it? ____ If so, is her menstrual history normal? ____

Special considerations: _____

RECOMMENDATIONS AND RESTRICTIONS WHILE IN CAMP

Special diet _____

Special medicine (name it) _____

Swimming, diving _____

Strenuous activity _____

Other _____

I have examined the person herein described and have reviewed her/his health history. It is my opinion that she/he is physically able to engage in camp activities except as noted above.

Examining Physician _____, **M.D.**

(Signature required and exam within 24 months of camp)

Today's Date _____

Address _____

Phone (____) _____

City, State, Zip _____