



# ATTLEBORO YMCA SUMMER CAMPS 2012 CAMPER MEDICAL FORM

## PART I: To be filled out by Parent

Camper's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Gender: \_\_\_\_ Age: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

Business Address: \_\_\_\_\_ Phone: \_\_\_\_\_

If not available in an emergency, notify:

1. \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

2. \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

### Health History: (Check – giving approximate dates)

Frequent Ear Infections \_\_\_\_\_ Hay Fever \_\_\_\_\_ Chicken Pox \_\_\_\_\_

Heart Defect/Disease \_\_\_\_\_ Ivy Poisoning, etc. \_\_\_\_\_ Measles \_\_\_\_\_

Convulsion \_\_\_\_\_ Insect Sting Allergy \_\_\_\_\_ German Measles \_\_\_\_\_

Diabetes \_\_\_\_\_ Penicillin Allergy \_\_\_\_\_ Mumps \_\_\_\_\_

Bleeding/Clotting \_\_\_\_\_ Other drug Allergies \_\_\_\_\_ Asthma \_\_\_\_\_

Operations or serious injuries (dates) \_\_\_\_\_

Chronic or recurring illness: \_\_\_\_\_

Other diseases or details of above: \_\_\_\_\_

Name of dentist/orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance carrier: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

Any specific activities to be restricted? \_\_\_\_\_

Will your child require any medical prescriptions to be administered while at camp? Circle one: YES NO

If yes, please contact the Camp Administrator at (508) 409-0742 for a medicine administration form.

**Important:** Please notify the camp if the camper is exposed to any communicable disease within three weeks prior to camp attendance.

**Parent's Authorization:** This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except noted by me and the examining physician.

I hereby give permission to the physician selected by the camp director to order X-rays, routine tests and treatment for the health of my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or surgery for my child as named above. I also hereby give permission to the camp director or selected counsellors to practice first aid on my child in the event of an emergency situation.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ (over)

**PART II: Medical Examination - To be completed by licensed physician**

Medical examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

**Immunization History:**

Please record the month, day, and year of basic immunization and most recent boosters.

Vaccines	Date of Basic	Date of Last Booster
Diphtheria	1.	1.
Pertussis DPT*	2.	2.
Tetanus	3.	
_____ or _____		
Tetanus TD*		
Diphtheria		
_____ or _____		
Tetanus		
_____		
Oral Polio TOPV		
_____		
Injectable Polio		
_____		
Measles		
_____		
Rubella		
_____		
Other		
_____		
Tuberculin test given _____ (most recent)		

**CODE:                    V - Satisfactory                    X - Not Satisfactory                    O - Not Examined**

Height: _____	Weight: _____	B.P. _____
Eyes _____	Lungs _____	Allergy: (please specify) _____
Glasses _____	Abdomen _____	_____
Ears _____	Hernia _____	_____
Nose _____	Posture _____	General Appraisal: _____
Throat _____	Skin _____	_____
Genitalia _____	Extremities _____	_____
Heart _____		_____

**Recommendations and restrictions while in camp.**

Special Diet \_\_\_\_\_

Current Medications \_\_\_\_\_

Is parent sending medications? \_\_\_\_\_

Swimming/Diving \_\_\_\_\_

Strenuous Activity \_\_\_\_\_

Other \_\_\_\_\_

I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above:

Examining Physician: \_\_\_\_\_ M.D.

Telephone: \_\_\_\_\_ Address: \_\_\_\_\_

Date: \_\_\_\_\_