

CAMP TECUMSEH YMCA DAY CAMP HEALTH FORM

CAMP DATES (please circle each week your camper is attending)

1 2 3 4 5 6 7

This form must be completely filled out and returned to **Camp Tecumseh YMCA, 12635 West Tecumseh Bend Road, Brookston, IN 47923**, at least **15 days prior** to the start of your camp session. Please make all non-emergency calls to camp only between regular office hours, 8:00 a.m. – 5:00 p.m. (Eastern Time), Monday – Friday. Thank-you very much!

Name: _____ **Sex:** M F **Age:** _____
Last First Middle Initial

Birth Date: ____/____/____

Mother/Guardian #1: _____ **Home Phone:** (____) _____

Home Address: _____
Street & Number City State Zip Code

Work Phone: (____) _____ **Cell Phone:** (____) _____

Father/Guardian #2: _____ **Home Phone:** (____) _____

Home Address: _____
Street & Number City State Zip Code

Work Phone: (____) _____ **Cell Phone:** (____) _____

If neither of the above are available in an emergency, please notify:

Alternate Contact #1: _____ **Home Phone:** (____) _____
Name
Work Phone: (____) _____ **Cell Phone:** (____) _____

Alternate Contact #2: _____ **Home Phone:** (____) _____
Name
Work Phone: (____) _____ **Cell Phone:** (____) _____

Name of Dentist/Orthodontist: _____ **Phone:** (____) _____

Name of Family Physician: _____ **Phone:** (____) _____

Do you have family medical/hospital insurance? _____ **If yes, Policy Holder's Name:** _____

Employer through which insurance is obtained: _____

Carrier: _____ **Policy or Group #:** _____

Do you have family prescription drug insurance? _____ **If yes, Policy Holder's Name:** _____

Carrier: _____ **Policy or Group #:** _____

IMPORTANT - MUST BE COMPLETED FOR 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 camp activities, except as noted by the examining physician and/or I. I understand there is some inherent risk in activities at camp and accidents sometimes occur. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. 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, and 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 anesthesia and/or surgery for my child as named above. I agree that after a place is reserved he or she will remain until the end of the period unless necessary to withdraw due to illness as defined by the camp physician. I understand that no refunds are given if a child leaves early because of homesickness or for disruptive behavior as decided by the camp director. I give permission for Camp Tecumseh to use photos or videos of my child in promotional literature.

I understand that if my child has special health issues I must call the camp at least 90 days in advance of the camper's stay to determine if the camp can provide the level of health care needed by my child. I understand that YMCA Camp Tecumseh is not a healthcare facility and may not be able to reasonably care for my child's special needs. Health conditions requiring advance clearance include, but may not be limited to:

- Insulin Dependent Diabetes
- Cardiac Situations
- Asthmatics
- Seizure Disorders
- Autism
- Serious Food Allergies

Camp Tecumseh counselors are encouraging and patient and can help facilitate successful camp experiences for children with mild and moderate disabilities. Our programs are not designed for campers who need significant assistance or personal care, require constant one-on-one support, or have difficulty managing their behavior in group settings.

Parent/Guardian Signature: _____ **Date:** _____

Witness Signature: _____

CAMPER MEDICAL HISTORY – To be completed by Parent.

Health History: (check - giving approximate dates).

Allergies

Diseases

_____ Frequent Ear infections

_____ Hay Fever

_____ Rheumatic Fever

_____ Heart Defect/Disease

_____ Poison Ivy, etc.

_____ Chicken Pox

_____ Convulsions

_____ Insect Stings

_____ Measles

_____ Diabetes (onset)

_____ Penicillin

_____ German Measles

_____ Bleeding/Clotting Disorders

_____ Other Drugs

_____ Mumps

_____ Epilepsy (onset)

_____ Peanuts

_____ Asthma

_____ Tonsillitis

_____ Other Foods

_____ Strep Throat

Other diseases or details of the above: _____

_____ Mononucleosis

Operations or serious injuries (dates): _____

Chronic or recurring illness or Special Needs: _____

Immunizations are up-to-date: Yes No

Reason: _____

<p>✪ REQUIRED ✪ Date of last Tetanus Vaccine: _____ (Month/Year)</p>

Current medications (list name, dosage and time schedule). All medications must be in a correctly labeled original container and given to the Day Camp Director or Nurse each morning. **NO MEDICATIONS (PRESCRIPTION OR OVER-THE-COUNTER) WILL BE ALLOWED TO BE CARRIED WITH THE CAMPER UNLESS AUTHORIZED BY THE DAY CAMP NURSE.**

Are there any over-the-counter, non-prescription medications or ointments that SHOULD NOT be given to your child?
(i.e. Tylenol, bug repellent, Sudafed, etc.)

Recommendations and restrictions while at camp:

Swimming/Diving: _____

Strenuous Activity: _____

Other: _____

Special Diet: _____

IMPORTANT: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance, or if camper has been seen by a physician for any reason during this period.

Last Name:

First Name: