



Child's Last Name

First

Session(s) Dates

# Saginaw YMCA Camp Timbers Health History and Physical Form

**Important–Information below MUST be completed for attendance\***

I hereby give permission to the medical personnel selected by the Camp Director to provide routine health care; to administer medications; to order x-rays; routine tests; treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physicians selected by the Camp Director to secure and administer treatment, including hospitalization, for the person named above. YMCA Camp Timbers will make every attempt to notify you before making a doctor's appointment or an emergency room visit for your child while they are in our care. All minor medical needs will be cared for by the on-site Health Director without notification of parents.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*\*If for religious reasons you cannot sign this, contact the Camp for a legal waiver, which must be signed for Camp attendance.*

## Emergency Contact Information

Primary Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Secondary Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

*If neither is available in an emergency, notify:*

Name \_\_\_\_\_ Relation \_\_\_\_\_

Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

## Health History (Check if applicable. Include date of most recent occurrence.)

- |  |  |   |                                    |
|--|--|---|------------------------------------|
| <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Ear Infections  | <input type="checkbox"/> Migraines        | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Measles       | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Nosebleeds       | <input type="checkbox"/> Seizures  |
| <input type="checkbox"/> Convulsions   | <input type="checkbox"/> German Measles  | <input type="checkbox"/> Braces           |                                    |
| <input type="checkbox"/> Mumps         | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Heart Murmur     |                                    |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Behavior        | <input type="checkbox"/> Contact Lenses   |                                    |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Surgeries       | <input type="checkbox"/> Eating disorders |                                    |

Other Health concerns or details of any of the above: \_\_\_\_\_

**ATTENTION**

Health History form **MUST** be accompanied by:

- 1) Copy of insurance card (front and back)
- 2) Copy of Immunization record
- 3) Camp physical with physician's signature (see back)  
OR School / Sports physical with physician's signature

# Health Care Examination / Recommendations by Licensed Medical Personnel

Camper Name: \_\_\_\_\_ Birthday \_\_\_/\_\_\_/\_\_\_ Male / Female  
BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant  is  is not able to participate in an active camp program.

Is the applicant currently under the care of a physician?  Yes  No If yes, why? \_\_\_\_\_

## Recommendations and Restrictions at Camp

Medically-prescribed meal plan or dietary restrictions: \_\_\_\_\_

Medication Allergies	Describe reaction and management/treatment
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_____	_____
_____	_____

Food Allergies/Dietary Restrictions	Describe reaction and management/treatment
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_____	_____
_____	_____

Other Allergies	Describe reaction and management/treatment
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_____	_____
_____	_____

Restrictions/Limitation of Camp activities? (e.g. what cannot be done, what adaptations are necessary, etc.)

\_\_\_\_\_  
\_\_\_\_\_

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

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_