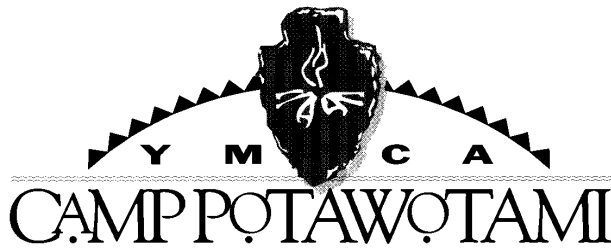


**A**



**2010**

**2010 Health History Form**

This form must be completed and signed by the camper's parent or legal guardian. It may not be completed by a grandparent or other relative who is paying for camp. *This form must be completely filled out for attendance and returned to Camp Potawotami by May 15, 2010.*

**Participant's Information**

Name: \_\_\_\_\_ Gender: \_\_\_ Male \_\_\_ Female  
Last First Middle

Birthdate: \_\_\_\_\_ Age at Camp: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

\*\*\*\*\*

Parent/Guardian #1: \_\_\_\_\_

Address (If different from above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

\*\*\*\*\*

Parent/Guardian #2: \_\_\_\_\_

Address (If different from above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

\*\*\*\*\*

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

Alternate Contact #1: \_\_\_\_\_ Home Phone: \_\_\_\_\_

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

Alternate Contact #2: \_\_\_\_\_ Home Phone: \_\_\_\_\_

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

**Insurance Information**

Do you have family medical/hospital insurance: \_\_\_\_\_ If yes, Policy Holder's Name: \_\_\_\_\_

Employer through which insurance is obtained: \_\_\_\_\_

Carrier: \_\_\_\_\_ Policy or Group #: \_\_\_\_\_

**A copy of your insurance card/cards should be attached to this form.**

Mail to: YMCA Camp Potawotami – P.O. Box 38 – South Milford, IN 46786

# Health History

Please circle all YES answers and explain them below, noting the number of the question and applicable dates. (Please attach an additional sheet of paper if necessary.)

- |   |   |
|---|---|
| 1. Had any recent injury, illness, or infections?         | 18. Have an orthopedic appliance being brought to camp?                     |
| 2. Have a chronic or recurring illness/condition?         | 19. Have any skin problems?   |
| 3. Ever been hospitalized?                                | 20. Have diabetes?  |
| 4. Ever had surgery or serious illness?                   | 21. Have asthma?  |
| 5. Have frequent headaches?                               | 22. Have epilepsy?  |
| 6. Ever had a head injury?                                | 23. Had problems with diarrhea/constipation?                                |
| 7. Ever been knocked unconscious?                         | 24. Have problems sleepwalking?   |
| 8. Wear glasses, contacts, or protective eyewear?         | 25. Have a history of bed-wetting?  |
| 9. Ever had frequent ear infections?                      | 26. Ever had an eating disorder?  |
| 10. Ever passed out during or after exercise?             | 27. Ever had emotional difficulties for which professional help was sought? |
| 11. Ever been dizzy during or after exercise?             | 28. Had mononucleosis in the past 12 months?                                |
| 12. Ever had seizures?                                    | 29. Ever had chicken pox?   |
| 13. Ever had chest pain during or after exercise?         | 30. Ever had rheumatic fever?   |
| 14. Ever had high blood pressure?                         | 31. Ever had measles, German measles, or mumps?                             |
| 15. Ever been diagnosed with a heart murmur?              | 32. If female, started menstruation?  |
| 16. Ever had back problems?                               | 33. If female, have an abnormal menstrual history?                          |
| 17. Ever had problems with joints (e.g. knees or ankles)? |   |

---



---



---

The participant has the following allergies:  HAY FEVER  IVY POISONINGS  INSECT STINGS  PENICILLIN  ANIMAL

Please list any other allergies and describe reaction and management of allergies below.

---



---



---

The participant has the following dietary restrictions:  RED MEAT  PORK  DAIRY PRODUCTS  POULTRY  SEAFOOD  EGGS

Please list any additional restrictions either dietary or activity below.

---



---



---

Please use the following space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which Camp Potawatami should be aware. (Please attach an additional sheet of paper is necessary.)

---



---



---

**Immunization Records:** Please fill out the following table or attach a copy of your school immunization records.

Immunization	Dose 1	Dose 2	Dose 3	Dose 4
DTP: Diphtheria, Tetanus, Pertussis				
TD: Tetanus Booster		Must be current within past 10 years		
MMR: Mumps, Measles, Rubella		Measles booster (required prior to 7th grade)		
IVP/OPV: Polio				
HepB: Hepatitis B				
Hib: H.				

I certify this Health History is correct to the best of my knowledge, any changes to this form will be provided to the Health Official upon the participant's arrival to camp. I certify that the participant is in normal health and able to participate in camp activities, except as noted. I understand that there is some inherent risk in activities at camp and accidents sometimes occur. I understand that the camp fee does not include accident insurance.

I hereby give my permission to the medical personnel selected by YMCA Camp Potawatami to order x-rays, routine tests, and treatments; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for the participant named above. In the event I cannot be reached in an emergency, I hereby give permission to the medical personnel selected by YMCA Camp Potawatami to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for the participant named above.

I understand and agree that while the participant is at YMCA Camp Potawatami all medications, prescription and over-the-counter, must be stored and administered by the designated Health Official, or certified staff member. All medications brought to camp must be in their original packaging/bottle that identifies the prescribing physician, name of medication, dosage, and frequency of administration. I hereby give my permission to the designated Health Official, or certified staff member, to dispense over-the-counter medications, such as Tylenol or Motrin, to the participant named above as deemed necessary.

This completed form may be photocopied for trips out of camp.

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

Printed Name \_\_\_\_\_