Camp Health Form 2018

Select Session: ❍ Both Sessions ❍ First Session ❍ Second Session

Ahava ❍ Chaverim ❍ Tzefas Tzfat ❍ Tiyulim ❍ ❍ Kinneret Kinneret Plus ❍

Teen-Travel & Training ❍ Tiyulim ❍ Y-HO-CA ❍ Y-HO-CA Plus ❍ CIT ❍ Staff ❍

Camper's Name____ ☐ **Male** ☐ **Female**

(Last) (First)

Camper's Birth Date____________ **Grade in September 2018**_________

Address_______________________________________**City**___________________**State**______ **Zip**_____ **Home Phone**__________

Mother's Email ___________________________________ **Father's Email** _____________________________

Father's Name_________________________ **Work #** ___________________ **Cell #** ______________________

Mother's Name ________________________ **Work #** ___________________ **Cell #** ______________________

Emergency Contact 1_____________________**Emergency Tel #**_____________ **Cell**_________________________

Emergency Contact 2 ____________________**Emergency Tel #**_____________ **Cell**_________________________

Allergies ________________________________ **Medical Conditions** ______________________________

Medical Form /Immunization Record (Required By Law). Please have your Physician fill this portion out.

Physical Examination_____________________________ **Psycho-Social Exam**______________________________

Abnormal Findings (Be Specific):____

Date of Last Exam_________ **Allergies:**_______________________________________ **Restrictions:** _________________

Medical Insurance Information: Plan ____**I.D.** _______________________

Under what name? ____

Medication (if any) child is currently taking (at home) ____

Condition for which medication is being used ____

VACCINE TYPE	DISEASE MO/DAY/YR	1ST DOSE MO/DAY/YR	2ND DOSE MO/DAY/YR	3RD DOSE MO/DAY/YR	4TH DOSE MO/DAY/YR	5TH DOSE MO/DAY/YR	MO/DAY/ YEAR
DIPHTHERIA,TETANUS,PERTUSSIS (DPT) (IF Td, DtaP, or DT*, indicate in corner box)							
POLIO- ORAL POLIO VACCINE (OPV) (If Salk Vaccine, indicate IPV in corner box)							
MEASLES, MUMPS, RUBELLA (MMR)							
MEASLES					MEASLES SEROLOGY	DATE:	TITER:
RUBELLA					RUBELLA SEROLOGY	DATE:	TITER:
MUMPS					MUMPS SEROLOGY	DATE:	TITER:
HAEMOPHILUS B (HIB) **							
HEPATITIS B **							
VARICELLA- OR DATE OF DOSAGE							
OTHER SPECIFY:							

Printed Name of Physician_____________________________ Phone____________________

Physician's Signature___________________________

For office use only: Checked by camp nurse__________(initials) Date ____________________

PARENT/GUARDIAN AGREEMENT

I hereby authorize and give permission for my child to participate in all camp activities and trips. I recognize and understand that the possibility of an accident and/or injury exists associated with my child's participation and inclusion activities and/or trips. I hereby release, discharge, and/or indemnify and hold harmless the YM-YWHA of Union County, its employees and associated personnel against any claim by or on behalf of my child as a registrant of the camp as a result of my child's participation in activities and/or trips, including incidents related to my child's transportation to and from such activities or trips.

Date: ____________ Parent/Guardian's Signature ________________________

Print Parent/Guardian's Name _____________________________

CONSENT FOR MEDICAL TREATMENT

As parent/guardian of the camper listed on this form, I hereby grant my consent and permission to any duly authorized employee of the YM-YWHA of Union county to sent and approve emergency medical care by a duly licensed M.D., D.O., R.N., D.D.S., or hospital staff member to perform any procedure or treatment that will preserve the life, limb, or well-being of my child.

Date: ____________ Parent/Guardian's Signature ________________________

Print Parent/Guardian's Name _____________________________

No Over the Counter medication will be given.

All Rx medication must be in original packaging with clear directions