

YWCA HEALTH FORM

TO BE COMPLETED BY THE PARENT or GUARDIAN

Each child must have a completed Health Form on file in the Camp Office at least two weeks before starting.

Camper's Name: _____ Gender: _____ Age: _____ DOB: _____

EMERGENCY INFORMATION:

I understand that YWCA staff is trained in the basics of first aid and CPR and I authorize them to administer such when appropriate. I also understand that the YWCA will make every effort to contact me in the event of an emergency requiring medical attention for my child. If I am unable to be reached, I authorize the YWCA to transfer my child to the nearest medical care facility.

Child's Doctor: _____ Office Number: _____

Street _____ City _____ State _____ Zip _____

EMERGENCY CONTACTS:

The YWCA will FIRST try to contact, you, the parent/guardian of the camper listed on the Enrollment Application. If you are **unable** to be reached, we have your permission to contact the following people:

1st Choice _____ Relationship: _____

Day Phone #1: _____ Day Phone #2: _____ Day Phone #3: _____

Address/City/ST/Zip: _____

2nd Choice _____ Relationship: _____

Day Phone #1: _____ Day Phone #2: _____ Day Phone #3: _____

Address/City/ST/Zip: _____

3rd Choice _____ Relationship: _____

Day Phone #1: _____ Day Phone #2: _____ Day Phone #3: _____

Address/City/ST/Zip: _____

INSURANCE INFORMATION:

The above named child is covered by health insurance: YES NO If Yes, provide the following information to expedite emergency treatment:

Policy Holder's (PH) Name: _____

Address: _____ Relation to Camper: _____

PH's Employer: _____ Work #: _____

Insurance Company Name: _____ Policy #: _____ Plan #: _____

Phone number of Insurance Company: _____

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Camper's Name: _____

MEDICAL INFORMATION

Physician's Name: _____ Tel: _____

Dentist's Name: _____ Tel: _____

Date of Last Health Exam: _____

Is the child *currently* under the care of a physician or psychologist?

YES NO

If YES, explain: _____

Child's Weight _____ Height: _____

Eye Color: _____ Hair Color: _____

Please complete the following if your child takes medication. Please note that medication must come to camp in its original container, clearly marked with the camper's name, date, dosage and times to be given.

Name of Medication	Used to Treat What Condition	Side Effects

Has your child experienced any of the following? If YES, please explain:

ergies:	<input type="checkbox"/> Yes:	
ergies:	<input type="checkbox"/> Yes:	
er	<input type="checkbox"/> Yes:	
vy, etc.	<input type="checkbox"/> Yes:	
tings/Bites	<input type="checkbox"/> Yes:	
Restrictions/Needs:	<input type="checkbox"/> Yes:	
s:	<input type="checkbox"/> Yes:	
hes:	<input type="checkbox"/> Yes:	
or contacts	<input type="checkbox"/> Yes:	
nt Ear Infections	<input type="checkbox"/> Yes:	
g/Clotting Disorders	<input type="checkbox"/> Yes:	
ivity restrictions?	<input type="checkbox"/> Yes:	

Has your child been diagnosed with any of the following?

sm	<input type="checkbox"/> Yes:	
/ ADHD	<input type="checkbox"/> Yes:	
ma:	<input type="checkbox"/> Yes:	
betes:	lin <input type="checkbox"/> Non-Insulin	
ng Disorder:	<input type="checkbox"/> Yes:	
ring Impaired	<input type="checkbox"/> Yes:	
rt Condition	<input type="checkbox"/> Yes:	
ures/Convulsions:	<input type="checkbox"/> Yes:	<input type="checkbox"/> Moderate <input type="checkbox"/> Severe
er Health Problems?	<input type="checkbox"/> Yes	

I affirm, to the best of my ability, that the information provided is true and valid.

Signature Parent/Guardian

Date