



YMCA CHEERIO ADVENTURES HEALTH FORM

2010

PERSONAL INFORMATION

Name Last First MI Birthdate Age at Cheerio Gender M F Parent/Guardian's Name Home Telephone Number Street Address (Not PO Box) City State Zip Mother's Work Phone Mobile/Pager Father's Work Phone Mobile/Pager

IN CASE OF EMERGENCY AND PARENT IS NOT AVAILABLE CONTACT: (must be completed)

1. Name Mobile Phone Day Phone Night Phone 2. Name Mobile Phone Day Phone Night Phone Camper's Physician Phone Camper's Dentist/Orthodontist Phone Health Insurance Company Policy Number Company Address Phone Name of Subscriber Relationship to Camper

TREATMENT/EMERGENCY CARE AUTHORIZATION

The above information is correct and complete to the best of my knowledge, and the Cheerio participant described has my permission to participate in all camp activities except as noted by me and/or the examining physician. I hereby give permission to the medical personnel selected by the camp director to provide and/or order medical treatment, x-rays and/or routine medical tests and to provide or arrange necessary related transportation for the participant named above.

Signature of Parent or Guardian Relationship Date

HEALTH HISTORY

Has the participant had or presently have (please check all that apply):

Asthma* Diabetes* Headache/Head Injury Recent Illness/ Injury/ Hospitalization/ Surgery Attention Deficit Disorder Ear Infections Joint Problems Seizures Bed-wetting Emotional Disorder Menstrual Problems Sleep Walking Blood Disorder Fainting/Dizzy Spells Orthodontic Appliance Other (please describe)

*Call camp office (336-869-0195) to request our asthma/diabetes information sheet so we may take better care of your child.

Please Explain Checked Items:

IMMUNIZATION HISTORY

Provide month and year. Starred (*) items must be current.

DPT Hepatitis B *Tetanus Booster (DT or T) Haemophilus Influenza B (HIB) *Polio Varicella (chicken pox) *MMR TB

MEDICATIONS * Please see the next page for medication restrictions

DOES NOT take medications on a regular basis. DOES take routine medication. (Please list below) Medication Dosage Time(s) Taken Purpose of Medicine

ALLERGIES

Food Allergy Yes No Allergic to: Describe reaction if this food is eaten and what is done to manage it Other Allergies (bees, latex, environmental substances, etc.) Yes No Allergic to: Medication Allergy Yes No Allergic to: Type of Reaction

CABIN

MI

First

Last

NAME

PLEASE NOTE THE FOLLOWING MEDICATION RESTRICTIONS:

1. Prescription medications must be in **ORIGINAL PHARMACY CONTAINERS** and labeled with participants **FIRST AND LAST NAME** and with **MEDICATION NAME AND CORRECT DOSAGE INSTRUCTIONS. DOSAGE WILL NOT BE GIVEN CONTRARY TO WHAT IS WRITTEN WITHOUT A DOCTOR'S PRESCRIPTION.**
2. **Vitamins, herbals and over-the-counter medications** and other non-prescription drugs will **NOT** be accepted without a doctor's order or prescription. (The camp health center stocks benadryl, ibuprofen, tylenol, sudafed, robitussin, pepto-bismol, immodium, milk of magnesia and other common over-the-counter medicines.)
3. All such medications, vitamins, and over-the-counter preparations must be in **ORIGINAL PACKAGING** and **WITH CURRENT EXPIRATION DATES.**
4. Campers are **NOT** permitted to keep any type of medication, vitamins, herbal preparations, prescription creams and/or over-the-counter preparations with them in the cabins. (Exceptions are made on a case-by-case basis for inhalers for asthmatics.)
5. The cost of any prescription(s) filled for a camper during his/her camp stay will be borne by the parent(s). Every effort will be made to assist in achieving payment by the camper's insurance carrier. Payment for any out-of-pocket expense advanced by the camp is expected when the camper is picked up on the closing day of the camper's session.

GENERAL HISTORY

Has had the following childhood illnesses [please indicate date(s)]:

Measles _____ Chicken pox _____ German Measles _____ Mumps _____

Participant's Physician _____ Phone _____

Address _____

Participant's Dentist/Orthodontist _____ Phone _____

Address _____

If the participant receives care or takes medications for emotional, learning and/or psychological concerns, please provide background information so we might work effectively with him/her.

DIET

Eats a regular diet Vegetarian Lactose intolerant

Other (please describe) _____

ACTIVITY

No Restrictions

Restrictions (please describe) _____

MEDICAL EXAMINATION (Completed by Physician)

This information must be completed by a licensed physician or nurse practitioner based on a physical examination which must have been performed **WITHIN THE LAST YEAR.**

Date of physical examination _____ Height _____ Weight _____

Date this form is being completed _____ Blood Pressure _____

This person is under the care of a physician for the following: _____

The participant is currently receiving the following medical treatment for the above listed condition(s): _____

Treatment(s) to be continued while at Camp Cheerio: _____

Medication(s) to be administered at Camp Cheerio (include name, dosage & frequency): _____

Dietary Restrictions while at Camp Cheerio: _____

Known Allergies (to medications, food, latex or other substances) and type of reaction _____

Treatment for above-listed allergies: _____

Physical limitations or restrictions while at camp: _____

Additional health information needed for a good camp experience: _____

Signature of Physician/NP _____

Printed Name and Title: _____

Address _____ Phone _____

