

YMCA Day Camp Health Form

Please return to the YMCA by June 1st with any balance due

Camper's Name _____

Birthdate _____ Age _____ Sex _____

Height _____ Weight _____

Number of years at YMCA Day Camp _____

Name 2 people you would like in your group. Ages must be relatively close.

1. _____ 2. _____

Health History

1. Child is allergic to _____

2. Child can not eat/drink the following. _____

3. Child has a history of Asthma, Epilepsy, Diabetes other _____
_____. This needs to be treated by _____

4. Child is on the following medications. _____

These need to be administered at what time: _____

5. Date of last physical _____

6. Date of last tetanus shot _____

7. Child was recently exposed to these communicable diseases: _____

8. Other medical or emotional information that might be helpful to the Camp Director or counselor _____

9. Family Doctor _____ Phone _____

I hereby give permission for _____ to attend YMCA Day Camp sponsored by the Red Wing Family YMCA. I give permission for my child to participate in all camp activities and be transported via YMCA vehicle or Bus. We or I (Parents/Guardians) have read and agree to all conditions of YMCA Day Camp. In the event of an emergency, I authorize First Aid treatment, hospitalize, order injections, anesthesia, or surgery for my child, if necessary, in the event that I, or my emergency contact cannot be reached.

Signature of Parent or Guardian

(Turn over please)

EMERGENCY CONTACT INFORMATION

1ST Parent's (Guardian's) Name _____
Place of Employment _____
Daytime Phone Number _____ Evening Phone Number _____

2nd Parent's (Guardian's) Name _____
Place of Employment _____
Daytime Phone Number _____ Evening Phone Number _____

In the event that the people above cannot be reached please contact:

Name _____ Relationship _____
Address: _____
Daytime Phone Number _____ Evening Phone Number _____

The camp plans a safe and healthy atmosphere. This information is only a precautionary measure. First Aid will be administered on location by the trained camp staff. If further treatment is required, the child will be transported to a clinic or hospital. Parents will be notified immediately of an emergency or serious problem.

INSURANCE INFORMATION:

Name of family member who carries insurance: _____
Address: _____
Home Phone: _____ Business Phone _____

Insurance Co. _____
Address _____
City _____ State _____ Zip _____

Policy Number _____ Certificate Number _____

If Medicare, Suffix _____