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: _____

MORE →

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:

Drug Allergies:	☐ No	☐ Yes:	Explain:
Food Allergies:	☐ No	☐ Yes:	Explain:
Hay Fever	☐ No	☐ Yes:	Explain:
Poison Ivy, etc.	☐ No	☐ Yes:	Explain:
Insect Stings/Bites	☐ No	☐ Yes:	Explain:
Dietary Restrictions/Needs:	☐ No	☐ Yes:	Explain:
Dizziness:	☐ No	☐ Yes:	Explain:
Headaches:	☐ No	☐ Yes:	Explain:
Glasses, or contacts	☐ No	☐ Yes:	Explain
Frequent Ear Infections	☐ No	☐ Yes:	Explain
Bleeding/Clotting Disorders	☐ No	☐ Yes:	Explain:
Any Activity restrictions?	☐ No	☐ Yes:	Explain

Has your child been diagnosed with any of the following?

☐ Autism	☐ No	☐ Yes:	
☐ ADD / ADHD	☐ No	☐ Yes:	
☐ Asthma:	☐ No	☐ Yes:	
☐ Diabetes:	☐ Insulin	☐ Non-Insulin	
☐ Eating Disorder:	☐ No	☐ Yes:	
☐ Hearing Impaired	☐ No	☐ Yes:	
☐ Heart Condition	☐ No	☐ Yes:	
☐ Seizures/Convulsions:	☐ No	☐ Yes:	☐ Mild ☐ Moderate ☐ Severe
☐ Other Health Problems?	☐ No	☐ Yes	Explain

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

_____ _____

Signature Parent/Guardian **Date**