# YMCA Health Form

**FOR CAMP PROGRAMS:**
Please bring this completed form with you on your first day of camp.

**Rogue Valley Family YMCA,** 522 West Sixth Street, Medford, OR 97501 **541-772-6295** www.rvymca.org

The information on this form is not part of the participant or staff acceptance process, but is gathered in an effort to assist us in identifying appropriate care, when needed. The YMCA Health Form must be filled out by the parents/guardians of minors or by adults themselves. An updated YMCA Health Form is required at the start of participation, annually and at the start of the summer camp season.

**Participant's Name:** ____________________ **Birth Date:** __________ **Grade:** _____ **Sex:** _____

**Address:** ____________________ **City:** ________________ **State:** _____ **Zip:** ________

**Participant's School:** ________________ **E-mail:** ____________________________

**Primary Account Holder*:** ________________________________ **Phone #:** ____________

*Account Holder must be 18 years or older and can make changes to any information and is financially responsible for this participant

**Authorized User to Modify Account Information**:** ______________ **Phone #:** ____________

**This person can make changes to this participant's information/account, but is **not** financially responsible.

**Authorized Pick-Up(s):** Authorized Pick-ups are in addition to the above listed adults. Must be 16 years or older and authorized to pick-up.

**Pick-up 1:** ____________ **Phone #:** ____________ **Pick-up 2:** ____________ **Phone #:** ____________

**Pick-up 3:** ____________ **Phone #:** ____________ **Pick-up 4:** ____________ **Phone #:** ____________

**Pick-up 5:** ____________ **Phone #:** ____________ **Pick-up 6:** ____________ **Phone #:** ____________

**Pick-up 7:** ____________ **Phone #:** ____________ **Pick-up 8:** ____________ **Phone #:** ____________

**Allergies:** Please be specific (i.e. Pick-up, airborne, ingested) and describe reaction (i.e. swelling, rash, death)

Has your child ever been stung by a bee? ❒ YES ❒ NO

❒ Food (please specify): ________________________________________

❒ Poison Oak: ________________________________________

❒ Medications: ________________________________________

❒ Other: ________________________________________

**Dietary Restrictions:** Please be as specific as possible so we can offer alternatives when possible. If alternatives are hard to determine then parents/guardians may be asked to furnish required foods.

❒ No red meat ❒ No poultry ❒ No seafood ❒ No dairy products

❒ No eggs ❒ No pork ❒ Other: ________________________

**Insurance Information:** If you carry family insurance, please complete this section. The Rogue Valley Family YMCA does not provide insurance.

**Name of Insurance Company:** ____________________ **Policy Number:** ______________

**Participant's Medical Professionals:**

Name of Doctor: ______________________________ Phone: ____________

Name of Dentist: ______________________________ Phone: ____________

Name of Orthodontist: ______________________________ Phone: ____________

**Helpful Information:** Provide any additional information about the participant's behavior, physical, emotional, or mental health.

________________________________________________________________

________________________________________________________________

**Health History:** Check all applicable boxes and provide dates of condition(s). Attach extra sheets with additional information and/or protocols for treatments as needed. The intent for collecting the information below is to provide the YMCA personnel with a background needed to provide appropriate care. Please keep a copy of this form for your records. Please provide complete information so the YMCA personal will be aware of your needs.

❒ Heart defect/disease ______________________
❒ Therapy/Counseling ______________________
❒ Asthma ______________________
❒ ADD/ADHD ______________________
❒ Diabetes ______________________
❒ Mumps ______________________
❒ Bedwetting ______________________
❒ Sleepwalking ______________________
❒ Back problems ______________________
❒ Chronic or recurring illnesses ______________________
❒ Wears glasses/Pick-ups ______________________
❒ Head injuries ______________________
❒ Uses orthodontic appliance ______________________
❒ Recent head lice ______________________
❒ Convulsions/seizures ______________________
❒ Chicken pox ______________________
❒ Psychiatric treatment ______________________
❒ Ear infections ______________________
❒ Hypertension/high blood pressure ______________________
❒ Measles ______________________
❒ Skin conditions ______________________
❒ Frequent headaches ______________________
❒ Unconsciousness/passed out ______________________
❒ Chest pain during or after exercise ______________________
❒ Hepatitis A, B or C ______________________
❒ Eating disorder ______________________
❒ Surgeries or recent illnesses ______________________
❒ Other (explain below)

______________________________________________________________________

______________________________________________________________________

**Immunizations:** Are all immunizations up to date? ❒ Yes ❒ No Date of last tetanus shot (if known): ______________

**Physical limitations:** Please list any limitations and reasons for all listed limitations.

______________________________________________________________________

______________________________________________________________________

**Non-prescription medications:** Which of the following over-the-counter medications is the YMCA authorized to use as needed. In State Certified Child Care programs only sunscreen may be used.

❒ Acetaminophen (i.e. Tylenol) ❒ Ibuprofen (i.e. Advil) ❒ Antihistamine (i.e. Benadryl)
❒ Hydrocortizone cream ❒ Sunscreen ❒ Calamine/Caladryl Lotion (for insect bites, poison oak)

**Medications:** Please list all medications (including over-the counter or nonprescription drugs taken on a routine basis) that you are sending with your child. Medications must be in **ORIGINAL CONTAINERS** (if a prescription medication, child's name must be listed on the bottle) with specific instructions for proper dispensing. Send enough medication to last the entire length of the program. Over-the-counter and nonprescription drugs need to be labeled with child's name. Any medications sent to the program without written instructions will not be administered. Attach additional pages as needed.

❒ Participant takes NO medications on a routine basis **AND** NO medications have been sent with this person.

❒ Participant takes medications as follows:

Medication 1: ______________________ Used for: ______________________

Amount/dosage: ______________________ Time Taken: ______________________

Medication 2: ______________________ Used for: ______________________

Amount/dosage: ______________________ Time Taken: ______________________

Please identify any medications taken during the school year that child does not take during the summer:

______________________________________________________________________

**RELEASE, WAIVER AND INDEMNITY AGREEMENT:** I understand that the YMCA assumes no responsibility for injuries or illness that I may sustain as a result of my physical condition or resulting from my participation. I give permission to the medical service provider selected by the YMCA personnel to render medical treatment deemed necessary and appropriate. Payment of any resulting medical, hospital or related costs and expenses must be paid by me or my insurance.
I hereby agree for myself, my child, our respective heirs, assigns and legal representatives, to release, indemnify, and hold the YMCA and its officers, directors, board members, employees, volunteers and agents ("releasees") harmless from any and all claims and causes of action of any nature, whether caused by the alleged negligence of the releasees or otherwise, which I or my child may now or hereafter have against the releasees which may at any time arise as a result of any act or thing occurring in or arising out of my or my child's participation.
I authorize the YMCA staff, volunteers or their designee to render first aid services or call an ambulance or provide emergency transport services to my child or myself. I authorize the YMCA to have and use photographs, audio, and/or video of the applicant as may be needed for its public relations programs.
**I have read and understand this waiver.**

❑ Check here if you do not want your child's image used in promotional materials

Primary Account Holder / Guardian Signature:______________________ Date: __________

# Overnight Camp Additional Information Form

**Rogue Valley Family YMCA**, 522 West Sixth Street, Medford, OR 97501 **541-772-6295** www.rvymca.org

**Treatment:** Below is a list of basic over-the-counter medications that upon parent/guardian approval may be used to treat these minor health issues. We stock the below items (not all items available when away from stationary location) and you need not send them with your child to camp. When available we use the generic form of the name brands listed. Please indicate if your child may receive the recommended dosage for his/her age by **placing a check mark** in the box located before the medication. Persistent conditions or those needing a physician's care will be referred to the parent/guardian.

- ❒ Sunburn relief spray/cream (Solarcaine, Bactine, Aloe Vera)
- ❒ Antiseptic ointments (Bacitricin, Neosporin)
- ❒ Ear drops (for water in ears, wax build-up)
- ❒ Cough syrup (Robitussin, Vicks, Dimetapp)
- ❒ Anti-emesis (controls vomiting)
- ❒ Sore throat spray (Chloraseptic)
- ❒ Milk of Magnesia (for constipation)
- ❒ Anti-Diarrheal (Kaopectate, Imodium AD)
- ❒ Calamine Lotion (for insect bites, poison oak reactions)
- ❒ Glucose (for diabetic emergency)
- ❒ Ibuprofen (Advil)
- ❒ Acetaminophen (Tylenol)
- ❒ Cough Drops (Vicks, Chloraseptic)
- ❒ Decongestant (Sudafed)
- ❒ Antihistamine (Benadryl)
- ❒ Burn Gel (Aloe Vera)
- ❒ Antacids (Tums, Maalox)
- ❒ Sting-Ease (for insect bites)
- ❒ Anti-fungal powder, spray, cream (Tinactin)
- ❒ Tampons (female campers only)

**Female Campers Only:** If your camper has not started menstruating and begins at camp, what is your preference for explaining, teaching, and talking with your daughter?

______________________________________________________________________

______________________________________________________________________

**Additional Medications:** These are in addition to those listed above.

Medication 3: ______________________ Used for: ______________________

Amount/dosage: ______________________ Time Taken: ______________________

Medication 4: ______________________ Used for: ______________________

Amount/dosage: ______________________ Time Taken: ______________________

Medication 5: ______________________ Used for: ______________________

Amount/dosage: ______________________ Time Taken: ______________________

**Staff Notes at Check-in:**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**RELEASE, WAIVER AND INDEMNITY AGREEMENT:** I understand that the YMCA assumes no responsibility for injuries or illness that I may sustain as a result of my physical condition or resulting from my participation. I give permission to the medical service provider selected by the YMCA personnel to render medical treatment deemed necessary and appropriate. Payment of any resulting medical, hospital or related costs and expenses must be paid by me or my insurance. I hereby agree for myself, my child, our respective heirs, assigns and legal representatives, to release, indemnify, and hold the YMCA and its officers, directors, board members, employees, volunteers and agents ("releasees") harmless from any and all claims and causes of action of any nature, whether caused by the alleged negligence of the releasees or otherwise, which I or my child may now or hereafter have against the releasees which may at any time arise as a result of any act or thing occurring in or arising out of my or my child's participation. **I have read and understand this waiver.**

Primary Account Holder / Guardian Signature:______________________ Date: __________