



# YMCA Camp Copneconic Health History & Release Form

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. This form is to be filled in by parents/guardians of minors, or by adults themselves.

Your camper will attend camp: from \_\_\_\_\_ to \_\_\_\_\_ at \_\_\_\_\_ Day Camp \_\_\_\_\_ Resident Camp

Camper Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_  
Session Code \_\_\_\_\_ (Camp Use)  
Cabin Name or Group Number \_\_\_\_\_

Camper Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Birth Date \_\_\_\_\_ Age at Camp \_\_\_\_\_  
First Middle Last Month/Day/Year

Camper Home Address: \_\_\_\_\_  
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
to Camper: \_\_\_\_\_ Preferred Phone: (\_\_\_\_) \_\_\_\_\_

Home Address: \_\_\_\_\_  
(If different from above)

Second parent/guardian or other emergency contact: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
to Camper: \_\_\_\_\_ Preferred Phone: (\_\_\_\_) \_\_\_\_\_

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name(s): \_\_\_\_\_ Relationship \_\_\_\_\_  
to Camper: \_\_\_\_\_ Preferred Phone: (\_\_\_\_) \_\_\_\_\_

**Allergies:**  No Known Allergies  This camper is allergic to:  Food  Medicine  The environment (insect tings, hay fever, etc.)  
 Other (**Please describe below what the camper is allergic to and the reaction seen.**)

**Diet, Nutrition:**  This camper eats a regular diet  This camper eats a vegetarian diet  This camper has special food needs  
(**Please describe any special food needs.**)

**Restrictions: (The following restrictions apply to this individual.)**

**Does not eat:**  Red Meat  Pork  Dairy Products  Poultry  Seafood  Eggs  Other \_\_\_\_\_

**Restrictions:**  I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.  
 I have reviewed the program and activities of the camp an feel the camper can participate with restrictions.  
(**Please describe below**)

**Medical Insurance Information:**

This camper is covered by family medical/hospital insurance  Yes  No  
Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
Subscriber \_\_\_\_\_ Insurance Company Phone Number (\_\_\_\_) \_\_\_\_\_

**Include a copy of your insurance card; copy both sides of the card so information is readable.**

**Parent/Guardian Authorization for Health Care:**

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine test, and treatment related to the health of my child for both routine health care and in emergency situation. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for and order injection, anesthesia or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_  
Date: \_\_\_\_\_ to Camper \_\_\_\_\_

**If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.**

**General Health History:** Check "Yes" or "No" for each statement. Explain "Yes answers below.

Has/does the camper:

- |  |  |   |  |
|--|--|---|--|
| 1. Ever been hospitalized?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Had fainting or dizziness?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath?...   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Ever had back/joint problems?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have a history of bedwetting?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches?.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Have any skin problems?.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts or protective eyewear? <input type="checkbox"/> Yes <input type="checkbox"/> No |  | 20. Traveled outside the country in the past 9 months? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |

**Please explain "Yes" answers in the space below, noting the number of the question. For travel outside the country, please name countries visited and dates of travel.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Mental, Emotional, and Social Health:** Check "Yes" or "No" for each statement.

Has the camper:

- |   |  |
|---|--|
| 1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. During the past 12 months, seen a professional to address mental/emotional health concerns?.....                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a significant life event that continues to affect the camper's life?.....                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |

*(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)*

**Please explain "Yes" answers in the space below, noting the number of the question. The camp may contact you for additional information.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Health Care Providers:**

Name of camper's primary doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of dentist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Orthodontist: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury.

**Cross out those the camper should not be given.**

- |   |  |
|---|--|
| Acetaminophen (Tylenol)                                       | Ibuprofen (Advil, Motrin)                    |
| Phenylephrine decongestant (Sudafed PE)                       | Pseudoephedrine decongestant (Sudafed)       |
| Antihistamine/allergy medicine                                | Guaifenesin cough syrup (Robitussin)         |
| Diphenhydramine antihistamine/allergy medicine (Benadryl)     | Dextromethorphan cough syrup (Robitussin DM) |
| Sore throat spray   | Generic cough drops                          |
| Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) | Aloe   |
| Laxatives for constipation (Ex-Lax)                           | Calamine lotion                              |
| Antibiotic cream  |  |

**Medications Being Taken:**

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person **takes No medications** on a routine basis. OR  This person **takes medications** as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med #4 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Attach additional pages for more medications.  
Identify any medications taken during the school year that participant does/may not take during the summer \_\_\_\_\_

**Immunization History:** Provide the month and year for each immunization. Starred (\*) immunizations must be current. Copies of immunization forms from health care providers or state or local government are acceptable; if included, please staple to this page.

**Writing "Up To Date" is not acceptable.**

Immunization	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year
Diphtheria, Tetanus, Pertussis* (DTap) or TdaP)						
Tetanus booster * (dT) or TdaP)						
Mumps, Measles, Rubella* (MMR)						
Polio* (IPV)						
Haemophilus Influenzae Type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (Chicken Pox)						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) Test	Date:	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive
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Which of the following has the participant had?		
<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Hepatitis C
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hepatitis A	
<input type="checkbox"/> German Measles	<input type="checkbox"/> Hepatitis B	

**What Have We Forgotten to Ask?** Please provide in the space below any additional information about the camper's health that you think is important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.

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# Camper Release Form

To comply with the State of Michigan Law, YMCA Camp Copneconic must have the names of those adults you authorize to pick up your child. Please complete the following information and sign below. We will ask for photo identification at the time of pick up. **Please list all adults authorized to pick up your child including yourself.**

I give permission for \_\_\_\_\_ to be released to:

_____	_____
_____	_____
_____	_____

at the end of camp or should an emergency arise where my child has to leave camp.

Date: \_\_\_\_\_ Signature of Parent or Guardian \_\_\_\_\_

Please select a security word to be used in the event that the people listed above cannot pick up your child from camp. Both you and the person picking up the child will be asked to confirm the security word. Please contact the camp office before check out if this occurs.

## Authorization for Audio/Visual Records

As the Parent/Legal Guardian of \_\_\_\_\_ I understand that the YMCA may make certain reasonable recording of this camping event. Do you hereby authorize the YMCA to have and use reasonable photographs, slides, moving pictures, and audio/video tapes of your child for purposes of legitimate YMCA records, public relations and/or advertising?  YES  NO

**Parent(s)/Guardian(s): STOP here. The rest of this form is for camp use. Thanks!**

*Resident Camp Use Only*

Initial Screening

Date / Time: \_\_\_\_\_

Initials: \_\_\_\_\_

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Exit Note: Check one of the following:

*Resident Camp Use Only*

Left camp this day with no reported illness or injury symptoms.

Left camp this day with the following problem/concern:

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This person was told about the problem and instructed about follow-up: \_\_\_\_\_  
Date Initials