



**Cheshire YMCA Camping Services**  
**Health History and Examination Form**

Last: \_\_\_\_\_ First: \_\_\_\_\_  
Cabin #: \_\_\_\_\_

Please note that the information on this form is not part of the camper or staff acceptance process, and is gathered in order to assist camp staff in caring appropriately for your child. While we require a physical exam within 24 months of camp attendance, we require camper families to update this form annually with a physician's signature.

**Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
Last First Middle

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
Street Address City State Zip

**Emergency Contact Information**  
Primary Parent/Guardian: \_\_\_\_\_ Phone 1: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone 2: \_\_\_\_\_  
Secondary Parent/Guardian: \_\_\_\_\_ Phone 1: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone 2: \_\_\_\_\_  
If not available in an emergency, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_  
Do you have plans to be away from home (other than work) during campers stay?  No  Yes  
*If so, please remember to attach dates, location, and contact information*

**Is the participant covered by family medical/hospital insurance?**  Yes  No  
Cardholder's Name: \_\_\_\_\_  
Carrier/Plan Name: \_\_\_\_\_ Group No: \_\_\_\_\_  
Name of Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name of Family Dentist/Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

**Health History**  
Are there any physical, emotional, or behavioral issues camp should be aware of? Recent or on going medical treatment?  
 No  Yes (please note below, and remember to give detail on the **Parent Confidential Form**)  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** \_\_\_\_\_ Describe reaction & management of reaction \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Restrictions:**  
Dietary Restrictions:  none  no red meat  no poultry  no dairy  no seafood  no pork  no eggs  
Describe any restrictions to activity (e.g. what cannot be done, necessary limitations or adaptations, why the restriction?)  
\_\_\_\_\_  
\_\_\_\_\_

**Parent Authorization:** I attest that this health history is accurate and complete, and that the person described herein has permission to participate in all camp activities except as noted by me or the examining physician. I hereby give permission to Camp Takodah to provide routine health care, including prescribed medications, and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission for camp to arrange necessary related transportation for me/my child. If I cannot be reached in an emergency, I hereby grant permission to the physician selected by Camp Takodah to secure and administer treatment, including hospitalization, for the above named person. This completed form may be photocopied for use on trips out of camp.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Printed Name: \_\_\_\_\_

Please return this form with your final payment

**Physical Examination and Recommendations by Licensed Physician**

Date Examined: \_\_\_\_\_ \* we require exams to have been completed within 24 months prior to the camp session.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_

**Immunizations:**

	Date	Booster
DTP	_____	_____
DT (Tetanus/Diphtheria)	_____	_____
Tetanus	_____	_____
Polio	_____	_____
MMR	_____	_____
Measles	_____	_____
Mumps	_____	_____
Rubella	_____	_____
Haemophilus Influenza B	_____	_____
Hepatitis B	_____	_____
Varicella (chicken pox)	_____	_____

**Physical Exam**

(0 = not examined, 1 = satisfactory, 2 = unsatisfactory)

Skin \_\_\_\_\_ Eyes \_\_\_\_\_ Glasses/contacts \_\_\_\_\_  
 Nose \_\_\_\_\_ Throat \_\_\_\_\_ Teeth \_\_\_\_\_  
 Ears \_\_\_\_\_ Hearing(R) \_\_\_\_\_ Hearing(L) \_\_\_\_\_  
 Heart \_\_\_\_\_ Lungs \_\_\_\_\_ Skeletal \_\_\_\_\_  
 Abdomen \_\_\_\_\_ Genitalia \_\_\_\_\_ Hernia \_\_\_\_\_

**Tests:**

Urinalysis Glucose? \_\_\_\_\_  
 Albumin? \_\_\_\_\_  
 Tuberculin testing (type) \_\_\_\_\_  
 \*Blood count (if Indicated) \_\_\_\_\_

**Recommendations/Restrictions while at camp:**

Treatments to be continued at Camp? \_\_\_\_\_

Known Allergies, including medications: \_\_\_\_\_

Description of any limitation or restriction on camp activities (including diet): \_\_\_\_\_

Other information for Health Care staff at camp: \_\_\_\_\_

**Medications:**

Does the camper require any medications?  No  Yes (Please give details below)  
 Medication #1: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time administered: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

Medication #2: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time administered: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

Medication #3: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time administered: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

(Please note that we will not dispense any prescription or non-prescription medications without a physician's order/instructions)

**Signature of Licensed Physician:**

The above named person is in satisfactory condition and may engage in all camp activities except as noted above

Examining Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Physicians Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Camp Screening Record** (for camp use)

Date/Time Screened: \_\_\_\_\_ Updates/Adds to Health History noted:  Yes  No/None required

Meds Received: \_\_\_\_\_

Current Health Needs Identified: \_\_\_\_\_

Observational Notes: \_\_\_\_\_

Screened By: \_\_\_\_\_