

McGaw YMCA Camp Echo Health Form

Please complete in full and return at least **four weeks prior** to the participant's camping experience to:
McGaw YMCA, Program Support Office, 1000 Grove Street, Evanston, IL 60201.

Participant's Name (L, F) _____ Male Female Age _____ Birthdate _____
 Participant's Social Security # _____ I refuse to provide on this form. Call if needed for clinic visit or ER
 Parent/Guardian 1 _____ (H) _____ (W) _____ (C) _____
 Home Address _____ City _____ State _____ Zip _____
 Parent/Guardian 2 _____ (H) _____ (W) _____ (C) _____
 Home Address _____ City _____ State _____ Zip _____
If there is anyone other than a stranger to whom we should not release the participant, indicate here _____
 Person **other than** Parent/Guardians to contact in case of an emergency _____
 Relationship _____ (H) _____ (W) _____ (C) _____

Camp Echo does not provide health insurance for participants. Does the participant have any form of health coverage?

- No – *The participant or his/her parent/guardian will be financially responsible for the full amount of any medical bills.*
- Yes – **Photocopy both sides of your Health Insurance/ Medicaid Card. If photocopy will fit, cut to size and attach it here.**

Health Insurance Card

FRONT

**Insurance Company Phone Number
Must Be Legible**

*Cut photocopy to size and attach here.
If card is too large, attach/staple full sheet.*

Health Insurance Card

BACK

**Insurance Company Phone Number
Must Be Legible**

*Cut photocopy to size and attach here.
If card is too large, attach/staple full sheet.*

**REQUIRED AUTHORIZATIONS: SIGNED BY PARENT (OR ADULT PARTICIPANT) IN 2 PLACES
PLEASE READ AUTHORIZATIONS BEFORE SIGNING. *If you need more time, let us know.***

The information on this form is correct so far as I know, and the participant has my permission to engage in all camp activities that are part of the program they are enrolled in, as described in the brochure and parent packet, on or off camp property, **except as noted on the back of this form.** I understand that failure to complete all portions of this form could result in an injury or compound the danger of an injury.

• SIGN FOR GENERAL PERMISSION TO PARTICIPATE IN CAMP ECHO ACTIVITIES:

(signature) _____ (date) _____

I hereby give permission to the Camp Echo Health Officers, acting on behalf of the McGaw YMCA Camp Echo, to provide routine non-surgical health care; to administer prescription medications I've supplied, as well as over-the-counter medications* appropriate for the situation; and to transport the participant to the next level of medical care if required. In the event I cannot be reached in an emergency, I hereby give permission to the licensed health care provider selected by the Camp Director to secure and administer treatment, order x-rays, order routine tests, hospitalize, and order injection, anesthesia or surgery for the participant. This completed form may be photocopied for trips out of camp. I understand that I am financially responsible for medical bills due to office/ER visits and/or pharmacy charges.

• SIGN FOR PERMISSION TO TREAT AND TO ACCEPT FINANCIAL RESPONSIBILITY:

(signature) _____ (date) _____ **Call for a waiver refusing permission to treat**

* *If you want the Health Officer to call you before dispensing any over-the-counter drugs, circle: CALL FOR OTC PERMISSION*

HEALTH HISTORY: Completed by Parent/Adult, Reviewed by Licensed Health Care Provider

- 1. Has the participant had any of the following (childhood) diseases or illnesses? Write no, or yes and give approximate year. Chicken Pox _____ Measles _____ German Measles _____ Mumps _____
2. Has the participant had any serious illnesses or, major operations or medical treatments? _____ If yes, describe here: _____
3. Are the participant's immunizations up to date? _____ If no, explain: _____
4. Has the participant had a tetanus shot within ten years? _____ Answering no is permitted. If yes, give date: _____
5. Does the participant have any current infectious diseases? _____ If yes, explain: _____
Please let us know if the participant is exposed to any infectious diseases after submitting this form and before camp starts.

HEALTH STATUS: Completed by Parent/Adult, Reviewed by Licensed Health Care Provider

- 6. Does the participant have any known allergies or dietary restrictions we should know about? _____ If yes, circle or list: penicillin peanuts wheat/gluten beestings hay animal fur Other: _____
7. Does the participant have any physical conditions that may affect their participation at camp? _____ If yes, circle or list: asthma bed wetting hemophilia cancer lung disease nervous disorder orthopedic problem pregnancy epilepsy drug addiction alcoholism diabetes heart disease back/neck injury Parkinson's Disease lice or nits fainting hearing loss high/low blood pressure kidney disease Other: _____
8. Any recent broken bones or major injuries? _____ If yes, what? _____

If you answered "yes" to questions 6, 7, or 8 above, please list here any camp-related ACTIVITY RESTRICTIONS:

Please attach a separate sheet that describes the condition, the management plan, and anything our staff needs to do to help.

- 9. Does the participant have any mental/psychological needs that will impact on camp interaction and/or participation? _____
If yes, circle and/or list: anxiety disorder ADHD depression learning challenges oppositional defiant disorder eating disorder OCD bipolar disorder PTSD autism Other: _____

If you answered "yes" to question 9 above, please attach a separate sheet that describes the concern, the management plan (including meds), and the behaviors that will indicate to our staff that the participant needs professional referral or assistance. For campers, we also need a written recommendation from a professional supporting participation in our camp program. For staff, describe on the separate sheet the support needed from your supervisor to complement your management plan.

HEALTH EXAMINATION: Must be Completed by a Licensed Health Care Provider

Code: √ = Satisfactory X = Not satisfactory (Explain) O = Not examined

Height _____ Weight _____ B.P. _____ Hgb _____ Urinalysis _____ Hernia _____
Eyes _____ Ears _____ Nose _____ Throat _____ Teeth _____ Posture _____
Heart _____ Lungs _____ Skin _____ Arms _____ Abdomen _____ Legs _____

General Appraisal: _____ Please review the Health History, Health Status, and Restrictions provided above.

For females: Has she menstruated? _____ If no, does she know about it? _____ If yes, is menstrual history normal? _____

To your knowledge, is the participant on any medications? _____ If yes, please list here: _____

To your knowledge, will the participant be stopping the use of any of these medications while they are at summer camp? _____

Licensed Health Care Provider Please Read and Sign

I have examined the participant on (date)____/____/____ (must be within 24 months of attending camp) and have reviewed the health history, health status, and restrictions. He or she is physically able to engage in camp activities, except as noted.

Health Care Provider Name (print) _____ (signed) _____ Date _____

Address _____ City _____ State _____ Zip _____

Telephone (must include area code) _____ - _____ - _____