

McGaw YMCA Camp Echo Permission to Treat Form

Please complete in full and return along with other paperwork for your event.

Participant's Name (L, F) _____ Male Female Age _____ Birthdate _____
 Participant's Social Security # _____ Refuse to provide on this form. Call if needed for the Clinic or E.R.
 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 literature provided, 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]

1. Has the participant had any of the following (childhood) **diseases** or illnesses? Circle **no**, or give **approximate year** by **yes**:
Chicken Pox **no** **yes**: _____ Measles **no** **yes**: _____ German Measles **no** **yes**: _____ Mumps **no** **yes**: _____
2. Any **serious illnesses or, major operations / medical treatments**? Circle answer (and if **yes** explain below) → **yes none**
3. Are the participant's **immunizations up to date**? If **no**, explain: _____, and circle answer → **no yes**
3a. Has the participant been **vaccinated against H1N1 swine flu**? (**no** is permissible) circle answer → **no yes**
3b. Has the participant been **vaccinated against the seasonal flu**? (**no** is permissible) circle answer → **no yes**
4. Has the participant had a **tetanus shot within ten years**? If **yes**, give date: _____ (**no** is permissible) circle → **no yes**
5. Any **current infectious diseases**? If **yes** explain: _____, and circle answer → **yes none**
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]

6. Any **allergies or dietary restrictions** that we should know about? Circle answer (and if **yes** circle/list below) → **yes none**
penicillin peanuts wheat/gluten beestings hay animal fur Other: _____
7. Any **physical conditions** that may affect participation at camp? Circle answer (and if **yes** circle/list below) → → **yes none**
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 / major injuries**? If **yes**, list: _____, and circle answer → **yes none**
- If you answered “yes” to questions 6, 7, or 8 above, please list here any camp-related **ACTIVITY RESTRICTIONS:**

Attach a **separate sheet** that describes the **condition**, the **MANAGEMENT PLAN**, and **anything camp needs to do to help**.

9. Any **mental/psychological needs** that will have an impact on camp interaction/participation? Circle answer → **yes none**
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, 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.

LIST ALL SCHEDULED OR PRESCRIPTION MEDICATIONS:

- Medication #1:** _____ Name of Physician (if prescribed): _____
Dosage: _____ Given at (circle applicable): breakfast lunch dinner bedtime ... or ... as needed
Physician's Phone and Address (if prescribed): _____
- Medication #2:** _____ Name of Physician (if prescribed): _____
Dosage: _____ Given at (circle applicable): breakfast lunch dinner bedtime ... or ... as needed
Physician's Phone and Address (if prescribed): _____
- Medication #3:** _____ Name of Physician (if prescribed): _____
Dosage: _____ Given at (circle applicable): breakfast lunch dinner bedtime ... or ... as needed
Physician's Phone and Address (if prescribed): _____
- Medication #4:** _____ Name of Physician (if prescribed): _____
Dosage: _____ Given at (circle applicable): breakfast lunch dinner bedtime ... or ... as needed
Physician's Phone and Address (if prescribed): _____