Compor Hoolth	Camper Name:	Birth	Birth Date:A		
Camper Health History Form 2023	Male Female Nor	,	Resident Cabin Preference: Female Cabin		
	Home Address: Street	City	State	Zip	
	Primary Phone Number:	Secondary	Secondary Phone Number:		
	Authoriz	ed Pickup/Emergency Contact			
 Name	Relation	Best Phone Number	Second Phone Nu	mber	
Name	Relation	Best Phone Number	Second Phone Nu	mher	
Name	Relation	Best Phone Number	Second Phone Nu	mber	
		Camper Information	average		
<ul> <li>Camper has never been away from home overnight.</li> <li>Camper gets homesick.</li> <li>Camper cannot go into the water for medical reasons</li> <li>Camper must wear a lifejacket</li> <li>Camper wets the bed at night</li> <li>Camper needs reminders to use the bathroom</li> <li>Camper has run away before</li> <li>Camper needs encouragement to stay on task</li> <li>None of the above</li> </ul>		Camper follows directions: well occasionally never         What would you like your camper to accomplish at camp?			
		ounselor Information			
Any special needs, medica should be aware of: 	l restrictions, activiti	es to avoid, or other informa	ation your camper's	counselor	
		dian Authorization for Health Care			

The Akron Area YMCA and YMCA, YMCA Camp Y-Noah, will herein be referred to as 'Camp.'

The camper named has permission to participate in all camp activities, except as noted by me and/or the examining physician. I agree to waive any claims against Camp for injuries or damages that may result from participation in programs. I give permission to the physician selected by the Camp to provide routine health care, first aid, medication or treatment as determined by medical personnel. IN CASE OF EMERGENCY or medical care beyond the scope of camp facilities, I understand that every effort to notify listed contacts will be made. I authorize Camp personnel to act on our behalf and secure emergency medical treatment and grant permission to the attending physician to secure proper treatment for the named camper. **PERMISSION TO DISTRIBUTE**: I authorize Camp personnel to administer medication(s) to the named camper. I understand that all prescribed medications brought to camp *MUST* be in the pharmacy labeled container with camper's name, dosage, health care providers name and phone number. Camp personnel will distribute per the licensed physician instructions. I give permission for the leadership staff of Camp to use their discretion on sharing this information with appropriate staff. I give my consent for Camp to provide transportation related to Camp activities. I authorize Camp to take and use any photographs, comments, and videos of my child for promotional purposes. All information pertaining to the named camper is complete and accurate to the best of my knowledge.

Parent/Guardian Signature:\_\_\_\_

Date:\_\_\_\_\_

Please check this box if you do not give permission to treat.

Camper Health History Form 2023

Camper Name:\_\_\_\_\_

Birth Date:

	0	General	Health History		
Check "Yes" or "No" for each statement.	Expla	ain "Ye	s" answers. Has/does the camper:		
	YES	NO		YES	NO
1. Been hospitalized in the last 12 months?			17. Have problems falling asleep/sleepwalking?		
2. Had Surgery in the last 12 months?			18. Have problems with diarrhea/constipation?		
3. Have recurrent/chronic illnesses?			19. Traveled outside the country past 9 months?		
4. Had a recent infectious disease?			20. Ever been treated for ADD or AD/HD?		
5. Had a recent injury?			21. Ever been treated for emotional or		
6. Have diabetes?			behavioral difficulties or an eating disorder?		
7. Had seizures in the last 12 months?			22. During the past 12 months, seen a professional		
8. Had headaches in the last 12 months?			to address mental/emotional health concerns?		
9. Had fainting/dizziness in the last 12 months?			23. Does the camper have an individual education		
10. Ever had back/joint pain?			plan (IEP)?		
11. Wear glass, contacts, protective eyewear?			24. Had a significant life event that continues to affect the camper's life?		
12. Had asthma/wheezing/shortness of breath?			(History of abuse, death of a loved one, family change, adoption, foster care	e, etc)	
13. Passed out/had chest pain during exercise?			25. Any current physical, mental, or psychological		
14. Current medications, prescribed and			conditions requiring medication, treatment, or		
over-the-counter?			special restrictions or consideration while at camp?		
15. Had mononucleosis in last 12 months?			26 Name of the above		
16. If female, have problems with periods?			26. None of the above		
	unctions	. For #18	please name countries visited & dates of travel. For #22 please attach	а сору.	
	uestions				
	00010				
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			Care Providers		
	ł	Health-(			
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