HEALTH HISTORY, EMERGENCY CONTACT & CONSENT FORM
YMCA of METRO NORTH SUMMER DAY CAMPS

☐ HEALTH HISTORY ☐ PHOTO ☐ IMMNIZATION RECORD ☐ PHYSICAL

Attach or send a current PHOTO of your child; this photo will be kept in your child's file as part of our safety protocols. You can email it from your mobile device!

Camp Sachem – Saugus Family YMCA
campsachem@metronorthymca.org

Camp Eastman – Torigian Family YMCA
campeastman@metronorthymca.org

CAMPER'S NAME:_____ Date of Birth:_____ Age:_____

Home Address:_____ City:_____ Zip Code:_____

PARENT/GUARDIAN 1 INFORMATION/APPROVED TO DISMISS:

Name:_____ Home Phone:_____

Address:_____ City:_____ Zip Code:_____

Work Phone:_____ Cell Phone:_____

PARENT/GUARDIAN 2 INFORMATION/APPROVED TO DISMISS:

Name:_____ Home Phone:_____

Address:_____ City:_____ Zip Code:_____

Work Phone:_____ Cell Phone:_____

EMERGENCY CONTACTS/APPROVED TO DISMISS: Only issue these people a pick-up/dismissal pass provided by Camp.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Is there someone that you would like us to be aware of that **cannot** pickup your child? _____

_____

*Please note: If person listed above is also a legal parent/guardian, a court order is required to refuse release.

ADDITIONAL EMERGENCY CONTACT INFORMATION:

Travel location(s) and telephone number(s) of the camper's parent(s)/guardian(s) if the parent(s)/guardian(s) will be traveling while the camper is attending camp:_____

Name of campers' primary Health Care Provider or Health Maintenance Organization:_____

Address:_____ Phone: _____

Name of dentist(s):_____ Phone:_____

Name of orthodontist(s):_____ Phone:_____

PLEASE PROVIDE 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.

CAMPER'S NAME: _____

ALLERGIES: (do not leave blank)

☐ No known allergies. DESCRIBE BELOW FOR: ☐Food ☐Medication ☐Seasonal/Environmental (insect stings, hay fever, etc.)

☐ Other (Please describe below the allergy/reactions.) ☐Prescribed an Epi-Pen* ☐Prescribed Inhaler* *SEE PAGE 4

DIET/ NUTRITION:

☐ Camper eats a regular diet ☐ Vegan/Vegetarian ☐ Lactose intolerant ☐Gluten intolerant. ☐Other, please explain:

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 and feel the camper can participate with the following restrictions or adaptations:

QUESTIONNAIRE: PHYSICAL, MENTAL, EMOTIONAL, SOCIAL, AND GENERAL HEALTH HISTORY

Has/does the camper:

1.	Ever been hospitalized?	☐Yes	☐No	11.	Have problems with menstruation/periods?	☐Yes	☐No
2.	Ever had surgery?	☐Yes	☐No	12.	Have problems with sleepwalking?	☐Yes	☐No
3.	Had a recent infectious disease?	☐Yes	☐No	13.	Ever had back/joint problems?	☐Yes	☐No
4.	Had a recent injury?	☐Yes	☐No	14.	Had asthma/wheezing/short breath?	☐Yes	☐No
5.	Had headaches?	☐Yes	☐No	15.	Have a history of bed-wetting?	☐Yes	☐No
6.	Wear glasses/contacts?	☐Yes	☐No	16.	Had seizures?	☐Yes	☐No
7.	Had fainting or dizziness?	☐Yes	☐No	17.	Have problems with diarrhea/constipation?	☐Yes	☐No
8.	Passed out/chest pain during exercise?	☐Yes	☐No	18.	Have diabetes?	☐Yes	☐No
9.	Had mononucleosis during the past year?	☐Yes	☐No	19.	Have any skin problems?	☐Yes	☐No
10.	Have recurrent/chronic illnesses?	☐Yes	☐No	20.	Traveled outside USA the past 9 mos.?	☐Yes	☐No

21. Take any medication during the school year that he/she will not be taken during the summer? ☐Yes ☐No
22. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)? ☐Yes ☐No
23. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐Yes ☐No
24. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐Yes ☐No
25. Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others).) ☐Yes ☐No
26. Have tuberculosis in a communicable form, or have evidence of symptoms of tuberculosis? ☐Yes ☐No
27. Take medication in the summer? (If yes, please fill out the authorization to administer medication to a camper form) ☐Yes ☐No

PLEASE EXPLAIN any YES answers in the following space, noting the number of the question.

PARENT/GUARDIAN AUTHORIZATIONS

I hereby authorize certified staff of the YMCA of Metro North to give First Aid and CPR to my child as needed. In the event of an emergency, I hereby authorize my child transported to the nearest medical facility as deemed appropriate by responding medical personnel, and secure necessary medical treatment including, but not limited to: hospitalization, injections, anesthesia and/or surgery. In the event that I cannot be reached, I hereby authorize the physician attending to my child to secure and administer treatment as necessary. I understand that the staff will make every effort to notify me and/or my emergency contacts of the emergency immediately. I authorize the YMCA of Metro North to contact and to release my child to the emergency contacts that I designate on this form.

I hereby confirm, 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 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.

PARENT/GUARDIAN SIGNATURE:

DATE: