YMCA
CAMP SEA GULL
CAMP SEAFARER
2019 Health Examination

THIS SIDE TO BE COMPLETED BY PARENT/GUARDIAN

CONTACT INFORMATION: Both natural parents' information is **required**

Parent 1: ______________________________ Parent 2: ______________________________

Home Phone: ( ) ______________________ Home Phone: ( ) ______________________

Work Phone: ( ) ______________________ Work Phone: ( ) ______________________

Cell Phone: ( ) ______________________ Cell Phone: ( ) ______________________

Email: ______________________________ Email: ______________________________

Primary Contact Parent: ____

Parents Are: ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Widowed ☐ Single

If neither parent can be reached, in case of emergency notify ____________________ Relationship: ______________

Home Phone: ( ) ____________ Work Phone: ( ) ____________ Cell Phone: ( ) ______________

Will your child require any prescription or over the counter medications while at Camp? ☐ Yes ☐ No

HEALTH HISTORY: **Please check (√) and attach a separate statement regarding potential problem areas:**

☐ Recurring Strep Throat
☐ Heart Disorder
☐ Serious Injuries
☐ Frequent Ear Infections
☐ Sleep Walking
☐ Severe Headaches/Migraines
☐ Concussions
☐ Bed Wetting
☐ Hepatitis
☐ Asthma / Wheezing / Chronic Cough
☐ Fainting
☐ Infectious Mononucleosis
☐ Chronic Constipation
☐ Seizures
☐ Kidney Problem / Urinary Tract Infection
☐ ADD / ADHD Learning Disabilities
☐ Cancer
☐ Celiac Disease/ Inflammatory Bowel Disease
☐ Diabetes

☐ Chicken Pox: (Date) __________________ Allergic Reactions: (Please give details) ______________________________

Insect Stings: ______________________________ Poison Ivy/Oak: ______________________________

Drug Allergies: ____

Is your child currently receiving treatment or counseling for emotional or behavioral issues? ☐ Yes ☐ No
If yes, include details and strategies for how we can best support your camper and manage the issue on a separate sheet of paper.

Are there other special concerns, or chronic diseases regarding your child's health or medical history?

____

Has your child menstruated? ☐ Yes ☐ No Has she been educated about menstruation? ☐ Yes ☐ No

DIET:
Is your child allergic to the following: ☐ Peanut ☐ Wheat ☐ Soy ☐ Other: ______________________
Will your child have dietary restrictions at Camp? ☐ Yes ☐ No
If yes, please select from the following: ☐ Vegetarian ☐ Gluten Free ☐ Dairy Free ☐ Egg Free ☐ Vegan

NOTE:
- Please write or call Camp if your child is exposed to or has contracted any potentially serious communicable disease (such as chicken pox, hepatitis, meningitis, etc.) during the three weeks prior to Camp attendance.
- In order to complete the registration process, this form (no substitutions) must be received by March 1 for physician's review.
- Falsification or lack of full disclosure of medical information may result in dismissal from Camp.
- Final acceptance is subject to review by the Camp Medical Committee and the Director reserves the right to rescind enrollment based upon recommendation of Camp medical staff / camper specialist.

PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR HEALTH INSURANCE AND PHARMACY CARD.

PERMISSION TO EXAMINE, PRESCRIBE MEDICATION AND TREAT: I hereby give permission to the Registered Nurse or Physician selected by the Camp Director to perform routine tests and treatment for the health of my child. In the event of an emergency or other acute event where time will not allow me to be reached, or I cannot be reached, I hereby give permission for the Camp Physician to secure necessary consultative care for my child, including hospitalization, anesthesia, surgery, and other medical treatment.

PERMISSION TO DISCLOSE INFORMATION: I agree to allow the Camp Physician or Health Clinic Director to speak with the Camp Director and Camp personnel living or working with my child, regarding any medications my child is taking, as well as specific medical or psychological conditions that may impact my child's daily living.

PERMISSION TO RELEASE RECORDS: I authorize the Camp Physician or Health Clinic Director to release any health records related to my child as may be necessary for treatment, referral, billing, or insurance purposes.

SIGNATURE OF PARENT OR GUARDIAN ______________________________ **Date** ______________

THIS SIDE TO BE COMPLETED BY PHYSICIAN

Camper's Name: ____ Date of Birth: ______________________________________

THE OBJECTIVES OF THIS EXAMINATION ARE TO DETERMINE THAT THIS CHILD:

1. Is physically fit to engage in strenuous activities without harm to himself/herself or others.
2. Has no significant infectious condition that could be transmitted to others.
3. Has no emotional or physical disorder that could not be cared for under the routine operations and programs of Camp. Some special conditions may be handled after individual discussions with Camp.

Weight: _________________ Height: _________________ B.P. _________________

Code: (☐) Normal; (X) Abnormal (Explain)

☐ Skin ____ ☐ Nose ____

☐ Chest ____ ☐ Extremities ____

☐ Eyes ____ ☐ Throat ____

☐ Heart ____ ☐ Spine ____

☐ Ears ____ ☐ Teeth ____

☐ Abdomen ____ ☐ Neurologic ____

Menstrual History: ____

Recommendations and restrictions (diet, activity restrictions): ____

____

Allergies: ____

Does the camper have chronic medical problems, emotional difficulties, eating disorders or behavioral issues of which you are aware?

☐ Yes ☐ No If yes, please describe the condition: ____

____

Does camper take routine medications or nutritional supplements? ☐ Yes ☐ No If yes, please list medications or nutritional supplements

(A prescription must accompany any medications or nutritional supplements listed through Realo).

____

To coincide with N.C. law for school enrollment, Camp Sea Gull and Camp Seafarer require the following immunizations:

Immunization					
*DTP / DTaP/ DT					
**dT/TdaP					
*Polio (IPV/OPV)					
***Hib					
****Hepatitis B					
*MMR (combined doses)					
*****Chicken Pox					
**Meningococcal					

*Required by NC State law

**Required by State law if child is 12 years or older

***Required by State law for children born on or after 10/01/88

****Required by State law for children born on or after 07/01/94

*****Required by State law for children born on or after 04/01/01

Date of most recent PPD (Mantoux) Test______________

Test results__________________

(If indicated according to AAP recommendations in the Red Book)

Recommended immunizations received in addition to those above required:

Immunization					
Pneumococcal					
HPV					
Hep A					
BCG/IPPD					

Print or Stamp

Physician's Name

Address

Phone Number

My signature indicates I have reviewed the Health History on the reverse side of this form as well as examined this patient on

_________________________ Date of Exam (within 12 months of arrival at Camp)

Signature of Physician ____