YMCA CAMP KANATA

HEALTH EXAMINATION FORM INSTRUCTIONS

PLEASE READ BEFORE COMPLETING HEALTH FORM

- Each camper is required to have a physical within **one year of Check-In.**
- **No camper will be allowed to remain at Camp without a 2018 Health Examination Form properly completed by a licensed physician and signed by the parent or guardian.**
  A complete Health Form includes a copy of the front and back of your insurance card.
- You must provide contact information for both parents. Please understand that we have an obligation to share health information with both parents. In the case of divorced parents, we will make every effort to contact both parents.
- Submit the front and back copy of your insurance card with your Health Form.
- The immunization record on the back of the Health Form needs to be complete or you may submit a copy of your child's immunization record provided by his or her physician's office.
- The front of the form has to be completed and signed by parent or guardian.
- The back of the form must be completed and signed by your physician, including the physician's name, address and phone number.
- **Please keep a copy of the completed form for your records.**

INSTRUCTIONS FOR SUBMITTING HEALTH DOCUMENTS:

- **Scan the front and back of: 1) your child's health form, 2) your insurance card, 3) immunization record, and email these as attachments to:**
  CampKanata@CampKanata.org
- To ensure your documents are scanned properly, please make sure they are scanned as a pdf, and not a photo. If using a smartphone, please consider using one of these free apps: Genius Scan, Tiny Scanner, or Cam Scanner.

YMCA CAMP KANATA
2018 Health Examination

Camper's Full Name: _____

Sex ☐ M ☐ F

This side to be completed by parent or guardian and signed prior to review by a physician. **Please note:** A licensed physician needs to perform a physical exam and sign this form within **12 months** of camper's arrival at camp.

Camper's Address: _____

Camper's Date of Birth: _____ Camper's Age at Camp: _____ Primary Contact Parent: _____

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

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

Parent 1 Name: _____
Home Phone: ( ) _____
Work Phone: ( ) _____
Cell Phone: ( ) _____
Email: _____

Parent 2 Name: _____
Home Phone: ( ) _____
Work Phone: ( ) _____
Cell Phone: ( ) _____
Email: _____

If neither parent can be reached, in case of emergency notify _____ Relationship _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

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: _____

Drugs: _____ Food: _____ Other: _____

Has your child been evaluated or received treatment or counseling by a psychologist or physician for an emotional or behavioral problem, including hyperactivity? ☐ Yes ☐ No If so, on a separate statement, please help us understand how to effectively address these concerns.

Are there other special concerns, or chronic diseases regarding your child's health or medical history? (Attach separate statement, if necessary)

_____

Girls Only: Has your daughter menstruated? ☐ Yes ☐ No Has she been told about menstruation? ☐ Yes ☐ No

NOTE:
- Please write or call the 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 June 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** _____

PHYSICAL EXAMINATION. 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.)

Weight: _____ Height: _____ B.P. _____

Please list any abnormalities (skin, eyes, ears, nose, throat, teeth, chest, heart, abdomen, extremities, spine, neurological)

_____

_____

Menstrual History: _____

Recommendations and restrictions (diet, activity restrictions): _____

_____

Allergies: _____

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

☐ Yes ☐ No If yes, please describe the condition. _____

_____

REQUIRED for Over the Counter Medications, Vitamins, Supplements Necessary at Camp: (Note: Items must be brought to camp in original packaging, including inhalers and epipens. Exceptions cannot be made. This is for your child's safety.)

Name of Medication/Item	Dosage (how much)	When (how often)	Special Instructions/ Notes

To coincide with N.C. law for school enrollment, Camp Kanata requires the following immunizations:

*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:

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 _____