

Wayne County YMCA After School Camper Health & Permission Form 2022/2023

A copy of your child's last doctors physical is required to register your child for After School.

Name: _____ Gender: ___ DOB ___/___/___ Age: ___ Grade: ___ Y Member: ___

Address: _____ Email: _____

Parent/Guardian's Name: _____ Employer: _____

Cell #: _____ Home#: _____ Work#: _____

Parent/Guardian's Name: _____ Employer: _____

Cell #: _____ Home#: _____ Work#: _____

Are there any siblings in the program? If so, please name. _____

In your opinion, is this child physically and emotionally able to participate in an After School Program like the one described in our literature? Y N If no, please explain: _____

Medical Treatment Policy: I understand that the YMCA does not normally administer any medication and will do so only when directed in writing by a parent or guardian. However I understand, in the event of an emergency in which a parent, guardian or emergency contact cannot be reached, that Emergency Medical Staff and the YMCA may take appropriate action to best serve the interest of my child. I understand in the case of an emergency situation, when medical attention is necessary, that the camper's parents or guardians will be responsible for any medical cost.

Therefore, in consideration of your acceptance of this registration: I hereby for myself, my heirs and assignees waive any and all claims for damages that I might have against the Wayne County YMCA staff, volunteers, the Board of Director's, the Honesdale Borough, Wayne Highlands & Wallenpaupack School Districts, Transportation Contractors and all field trip sites, for any and all injuries suffered by my child.

I, _____ (Parent or Guardian) have read, understand and agree to the Medical Treatment Policy stated above.

I, _____ (Parent or Guardian), authorize the YMCA to obtain emergency medical treatment for my child, _____, in case of emergency.

Emergency Contact (if parents cannot be reached)

Name: _____ Relationship: _____

Cell #: _____ Home#: _____ Work#: _____

Medication Being Taken:

Does this child take any medication on a regular basis? Yes No (If no proceed to back, if yes indicate below)

Med. #1 _____ Dosage _____

Reason for taking _____

Med. #2 _____ Dosage _____

Reason for taking _____

Will any of these medications need to be administered during camp hours? Yes No

If yes, which ones _____

****Please remit a physician's note denoting the prescription and dosage with this form. ****

Camper's Medical History & Insurance Information 2022/2023

General Questions (Explain yes answers below)

Has/Does the participant:

- | | | | | | |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| | yes | no | | yes | no |
| 1. Had a recent injury, illness or infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Ever been diagnosed with a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Ever had back problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | 17. Ever had problems with joints (e.g. knees, ankles) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have any orthodontic appliances being brought to camp? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have any skin problems? (e.g. itching, rash, acne) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious? | <input type="checkbox"/> | <input type="checkbox"/> | 21. Have Asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts or protective eye wear? | <input type="checkbox"/> | <input type="checkbox"/> | 22. Have mononucleosis in the last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had frequent ear infections? | <input type="checkbox"/> | <input type="checkbox"/> | 23. Had problems with diarrhea/constipation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have problems with sleep walking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been dizzy before or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 25. If female, have an abnormal menstrual history? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had seizures? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have a history of bedwetting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever had chest pain before or after exercise | <input type="checkbox"/> | <input type="checkbox"/> | 27. Ever had an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Ever had emotional difficulties for which
professional help was sought? | <input type="checkbox"/> | <input type="checkbox"/> |

Please explain any (yes) answers and note the question # _____

Are there any other restrictions, limitations or conditions (allergies, etc.) _____

Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis

Please give the date of the last immunization for:

- | | | | |
|--------------|----------------------------|--------------|------------------------------|
| Date: | Vaccine | Date: | Vaccine |
| _____ | DTP | _____ | Varicella Zoster |
| _____ | Rubella | _____ | TD (Tetanus / diphtheria |
| _____ | Tetanus | _____ | Haemophilus influenza B |
| _____ | Polio | _____ | Date of last TB Mantoux Test |
| _____ | Hepatitis B | _____ | Result _____ |
| _____ | Measles, Mumps and Rubella | | |

Name of Primary Care Physician: _____ Phone: _____

Address: _____

Insurance Carrier: _____ Group & ID #: _____

Name of Insured: _____ Relationship to camper: _____

Parent or Guardian Authorization: To the best of my knowledge this health history is correct and complete, and the person herein described has permission to engage in all camp activities except as noted.

Parent or Guardian's Signature: _____ Date: _____

Printed Name of Parent or Guardian: _____