# YMCA CAMP REED

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

**2019 HEALTH HISTORY FORM / PARENT PERMISSION FORM**
**DUE JUNE 1, 2019**

Any changes to this form should be provided in writing upon participant's arrival at camp. Please provide complete information so that the camp is aware of participant's needs.

**PLEASE INDICATE PROGRAM**

MINI SESSION #_____
TRAD. WEEK #_____
CIT GROUP #_____
○ Staff ○ JC

Participant's Name:_____ Nickname:_____

Boy___ Girl___ Date of Birth:_____/_____/_____ Grade (19/20 school year):_____ Age as of June 1, 2019:_____

Parent/Guardian Name:_____ Cell Phone:(_____)_____-_____ Home Phone:(_____)_____-_____

Parent/Guardian Name:_____ Cell Phone:(_____)_____-_____ Home Phone:(_____)_____-_____

Home Address_____ City_____ State_____ Zip_____

Emergency Contact #1_____Relationship_____Cell Phone(_____)_____-_____ Add'l Phone(____)_____-_____

Emergency Contact #2_____Relationship_____Cell Phone(_____)_____-_____ Add'l Phone(____)_____-_____

**Parent/guardian will be contacted **first** in an emergency. **If parent/guardian is unavailable**, emergency contacts will be called.

## MEDICAL INFORMATION

Name of family physician:_____ Phone: (_____)_____-_____

Name of family dentist/orthodontist:_____ Phone: (_____)_____-_____

**PAYMENT INFORMATION** (Required at clinic or hospital for any medical treatment)
**Please indicate method of payment:**

○ Self-pay: Please indicate name and address of person responsible for payment:_____

○ Private Insurance: Name of insured:_____ Relationship to participant:_____

Carrier or Plan Name:_____ Group#:_____ ID#:_____

○ Medicaid: ***Please attach a copy of participant's current Medicaid coupon***

***IMPORTANT** – *PHYSICAL SIGNATURE MUST BE PRESENT FOR PARTICIPANT TO ATTEND*

As parent or legal guardian, I agree to release and hold harmless the YMCA of the Inland Northwest and YMCA Camp Reed, their agents, assistants, employees and co-sponsors for any damage or injuries, physical or mental, which may occur as a result of my child's participation in activities in connection with YMCA Camp Reed programs. I understand and certify that participation in YMCA Camp Reed activities is completely voluntary and I have had the opportunity to familiarize myself with the camp program and activities in which my child will be engaging. I recognize that certain hazards and dangers are inherent in YMCA Camp Reed programs and particularly but not limited to, the activities of archery, arts and crafts, BB marksmanship, biking, boating, day and night hiking, horseback riding, pottery, high and low ropes courses, rock climbing wall, rappelling, riflery, sports, swimming, waterfront games, and 1-7-mile overnight hiking trips. I further understand that 13-14-year-old campers may take a 20-mile overnight bike trip which travels on public roads and that the CIT bike trip is 200 miles on public roads. All activities are more fully described on the YMCA Camp Reed website and program information, which I agree to read. I recognize the importance of knowing and abiding by YMCA Camp Reed's rules, regulations and procedures for the safety of camp participants. I acknowledge that although YMCA Camp Reed has taken safety measures to minimize the risk of injury to participants, YMCA Camp Reed cannot insure or guarantee that the participants, equipment, premises and/or activities will be free of all hazards, accidents or injuries. I understand that it is my responsibility to provide health insurance for my child. I certify that my child's information, as I have provided, is correct and complete as far as I know, and it is my opinion that my child is physically, emotionally and mentally able to engage in all camp activities, except as specifically noted. I hereby give permission to the YMCA Camp Reed staff to provide routine health care, dispense prescribed and over-the-counter medications, and seek emergency medical or dental treatment including ordering x-rays or tests deemed necessary by the health care providers. I give permission to the YMCA Camp Reed staff to arrange necessary transportation. In the event I cannot be reached in an emergency, I hereby give permission to the medical provider selected by YMCA Camp Reed staff to secure and administer treatment, including hospitalization, for my child. If there are any changes to health information provided for my child, I agree to provide the camp nurse with updated and accurate information IN WRITING at the time of check in. I agree to the release of any records necessary for insurance purposes. I agree to allow the YMCA and YMCA Camp Reed to use my child's image for YMCA and YMCA Camp Reed publicity and marketing purposes. This completed form may be photocopied or reproduced for trips out of camp.

**Signature of participant or parent/guardian if under 18:**_____**Date:** _____/_____/_____

**PRINT BOTH PAGES, SIGN HERE & RETURN**

**Printed Name**_____



**YMCA Camp Reed | 1126 N Monroe Spokane, WA 99201 | P: 509 777 9622 | F: 509 343 4096 | CampReed@ymcaspokane.org**

**MEDICAL INFORMATION PAGE 2** **Participant's Name:**_____

**PLEASE NOTE: If your participant has special health needs (including but not limited to: diabetes, cardiac illness, severe asthma, seizures, serious behavioral issues, or severe allergies), you must contact the camp director for advance clearance. On a case-by-case basis, we consult with parent/guardian and our camp health care provider to determine if accommodation and appropriate care is available.**

**PLEASE CHECK ALL BOXES** *(a response is needed for each)*

| | | | | | |
|---|---|---|---|---|---|
| Asthma | ◯Yes | ◯No | ADD/ADHD | ◯Yes | ◯No |
| Migraines | ◯Yes | ◯No | Cardiac Defect/Disease | ◯Yes | ◯No |
| Bedwetting | ◯Yes | ◯No | Crohn's Disease | ◯Yes | ◯No |
| Diabetes | ◯Yes | ◯No | Serious Behavioral Issues | ◯Yes* | ◯No |
| Seizures | ◯Yes | ◯No | Conditions Not Listed | ◯Yes* | ◯No |

*Please describe_____

**1.** Describe any other significant PAST medical treatment or history_____

_____

_____

**2.** Describe any CURRENT physical, developmental, or psychological conditions requiring medication, treatment, special restrictions, or considerations while at camp_____

_____

**3.** Is the participant presently under the care of a physician for any conditions? ◯Yes ◯No

Name and phone number of treating physician_____

Explain_____

**4.** Describe any camp activities from which the participant should be exempted for health or developmental reasons_____

_____

_____

**5.** Diet Accommodations* ☐Nut Free ☐Gluten Free ☐Vegetarian

*Camp Reed can accommodate these special diets listed above.

**PRESCRIPTION MEDICATIONS**

Participant takes medication: ◯Yes ◯No

***If yes, please note the following instructions:***

At check-in, deliver any prescription medications to check-in at camp and fill out a medication instruction card detailing dosage and frequency.
- Send in **original prescription bottle** and only enough for the length of camp. Do not refrain from sending meds if participant takes them at home.
- Our onsite camp nurse dispenses all prescription medications. **No medications of any type are allowed with participant or in the cabins.**
- Last dispensing of medications is Friday night. Saturday morning meds are not given. Medications are packed in bags Saturday morning.

**NON-PRESCRIPTION MEDICATIONS**

Utilizing medical history and discretion, camp health care provider will administer the following non-prescription medications in case of illness or injury.
I authorize the following non-prescription medications to be administered to participant by the camp health care provider as needed:

Acetaminophen (Tylenol) ◯Yes ◯No Cough syrup ◯Yes ◯No Antacid ◯Yes ◯No Ibuprofen ◯Yes ◯No

Loratadine (Claritin) ◯Yes ◯No Benadryl ◯Yes ◯No Sudafed ◯Yes ◯No

**ALLERGIES:** LIST ALL KNOWN (Medications, food, environmental, etc.)

| **Allergy** | **Check all that apply** | **Describe severity, typical reaction, and a preferred response** |
|---|---|---|
| _____ | ☐airborne / ☐ingested / ☐contact | _____ |
| _____ | ☐airborne / ☐ingested / ☐contact | _____ |
| _____ | ☐airborne / ☐ingested / ☐contact | _____ |
| _____ | ☐airborne / ☐ingested / ☐contact | _____ |

**IMMUNIZATION HISTORY (MANDATORY)** Is the participant current with the following:

Polio ◯Yes ◯No Mumps ◯Yes ◯No Rubella ◯Yes ◯No Diphtheria ◯Yes ◯No Pertussis ◯Yes ◯No Measles ◯Yes ◯No

Date of last Varicella (chicken pox): month/year_____ ◯Disease ◯Vaccine

Is Tetanus immunization current? ◯Yes –Month/year, if known_____ ◯No

*If camper is not vaccinated, please provide a Washington State Immunization Exemption form to YMCA Camp Reed by June 1, 2019. If your pediatrician and you participate in the online Washington Immunization Record, you can access your immunization information online at*: wa.myir.net



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# LETTER TO MY COUNSELOR AT YMCA CAMP REED

**Camper completes this side. Parent completes opposite side (pg. 4).** **CAMP SESSION:_____**

**Dear Counselor,**

My name is_____. My friends call me _____.

I am _____ years old. In Fall 2019 I will be in the _____ grade. My birthday is _____.

I have _____ brother(s), age(s)_____. I have _____ sister(s), age(s)_____.

The things I like to do for fun are _____

_____

I am good at _____

_____

_____

I am coming to Camp Reed because_____

_____

I hope to be able to do the following things at Camp Reed this summer: _____

_____

When I am at Camp Reed I don't want to _____

_____

_____

I get along with friends who _____

_____

Last summer I _____

_____

_____

I would also like you to know: _____

_____

_____

_____

**See you soon!**

_____

Signature

# LETTER TO MY CHILD'S COUNSELOR AT YMCA CAMP REED

**Parent completes this side. Camper completes opposite side (pg.3).**

**Name of camper:** _____

**Mail, fax, email or drop off this form & health history form.**
YMCA Camp Reed 1126 N Monroe Spokane, WA 99201
P 509 777 9622 | F 509 343 4096 | CampReed@ymcaspokane.org

**Dear Counselor,**

This is my child's _____ year at summer overnight camp and _____ at Camp Reed.

I want my child to go to camp because _____.

While at camp, I hope my child _____.

_____.

*My child is…*

…most happy when _____.

…most unhappy when _____.

…enthusiastic about _____.

…not fond of _____.

…apt to be afraid of _____.

He/she is _____ at taking care of personal belongings.

What behaviors do you most often have to speak to your child about? _____

_____

What methods of correcting these behaviors have you found effective? _____

_____

My child lives with (please name): Parent(s)/Guardian(s) _____

Brother(s)_____ Sister(s)_____ Others_____

My child has the following responsibilities at home:_____

My child is allergic to:

| Allergy | Check all that apply | Describe severity, typical reaction, and a preferred response |
|---|---|---|
| _____ | ☐airborne /☐ingested /☐contact | _____ |
| _____ | ☐airborne /☐ingested /☐contact | _____ |
| _____ | ☐airborne /☐ingested /☐contact | _____ |

Does your child have a learning, emotional, or behavioral condition? If yes, please explain: _____

_____

_____

Anything else you would like us to know? _____

_____

_____ (_____)_____-_____ (_____)_____-_____

**Parent/Guardian Signature** **Cell phone number** **Secondary phone number**

***If there is something of special importance or a major concern, please speak directly to your child's counselor at check-in.**