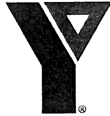

Attleboro YMCA

YMCA Activity Center-
2009 "E.L.P." Summer Enrichment Camp

Part I: Parent
Part II: Physician

Medical Form

Part I: Parent

Name: ______________________ Birth Date: ____________ Sex: _____ Age: _____

Parent or Guardian: ______________________ Phone: ____________

Home Address: ______________________________________

Business Address: ______________________ Phone: ____________

If not available in an emergency, notify:

1. ______________________ Phone: ____________

Address: ______________________________________

2. ______________________ Phone: ____________

Address: ______________________________________

Health History: (Check — giving approximate dates)

Frequent Ear Infections	_______	Hay Fever	_______	Chicken Pox	_______
Heart Defect/Disease	_______	Ivy Poisoning, etc.	_______	Measles	_______
Convulsions	_______	Insect Stings Allergy	_______	German Measles	_______
Diabetes	_______	Penicillin Allergy	_______	Mumps	_______
Bleeding/Clotting	_______	Other drug Allergies	_______	Asthma	_______

Operations or serious injuries (dates): ______________________________________

____

Chronic or recurring illness: ______________________________________

____

Other diseases or details of above: ______________________________________

____

Name of dentist/orthodontist: ______________________ Phone: ____________

Name of family physician: ______________________ Phone: ____________

Do you carry family medical/hospital insurance ? _________ If so, indicate:

Carrier: ______________________ Policy/Group #: ____________

Any specific activities to be restricted ? ______________________________________

____

Important: Please notify camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance.

IMPORTANT — Must be Completed for Attendance

Parent's Authorization: This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except noted by me and the examining physician.

I hereby give permission to the physician selected by the camp director to order X-rays, rountine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or surgery for my child as named above. I also hereby give permission to the camp director or selected counselors to practice first aid on my child in the event of an emergency situation.

Signature: ______________________ Date: ____________

Part II: Physican (on backside)

(over)

Part II: Physician **Medical Examination — To be filled out by licensed physician**

Medical examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Immunization History:
Please record the month, day, and year of basic immunization and most recent boosters.

Vaccines		Date of Basic	Date of Last Booster
Diphtheria Pertussis Tetanus	DPT *	1. 2. 3.	1. 2.
____ or			
Tetanus Diphtheria	TD *		
____ or			
Tetanus			
Oral Polio	TOPV		
Injectable Polio			
Measles			
Rubella			
Other			

Tuberculin test given ____________________ (most recent)

Code: **V - Satisfactory** **X - Not Satisfactory** **O - Not Examined**

Height: ____________ Weight: ____________ B. P. ____________

Eyes ____________ Lungs ____________ Allergy: (please specify)

Glasses ____________ Abdomen ____________ ______________________________

Ears ____________ Hernia ____________ ______________________________

Nose ____________ Posture ____________ General Appraisal:

Throat ____________ Skin ____________ ______________________________

Genitalia ____________ Extremities ____________ ______________________________

Heart ____________ ______________________________

Recommendations and Restrictions while in camp.

Special Diet ______________________________

Current Medications ______________________________

Is Parent Sending Medications ______________________________

Swimming/Diving ______________________________

Strenuous Activity ______________________________

Other ______________________________

I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted above.

Examining Physician: ______________________________ M.D.

Telephone: ____________________ Address: ______________________________

Date: ____________________