CAMP FOSTER YMCA

SESSION # _____

Please complete and return at least 1 week prior to check-in :
Camp Foster YMCA, PO Box 296, Spirit Lake, IA 51360

CONFIDENTIALITY AND SECURITY OF INFORMATION – PROTECTED HEALTH INFORMATION

We restrict access to non-public personal information to those employees who need to know that information to provide services to you and your child. Health forms are secured in either the main office or the Health Director's office until the end of summer camp season, and then they are stored in the camp archives.

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CAMPER HEALTH HISTORY & INSURANCE INFORMATION

Parents fill out Parts A,B,C,D

PART A CAMPER INFORMATION

Camper's Name _____ M/F (Circle One) D.O.B_____
Address _____ City_____State_____Zip_____

Father's Name _____Soc. Sec # _____
Father's Address _____Home Phone _____
Father's Employer _____Work Phone _____
Cell Phone _____

Mother's Name _____Soc. Sec # _____
Mother's Address _____Home Phone _____
Mother's Employer _____Work Phone _____
Cell Phone _____

Camper lives with: ❑Mom & Dad ❑Mom ❑Dad ❑Other _____

Family Doctor _____ Phone # _____

****IF PARENT CANNOT BE REACHED, OTHER PERSON(S) TO CONTACT WHILE CAMPER IS AT CAMP****

1. Name _____
   Day Phone _____
   Evening Phone _____

2. Name _____
   Day Phone _____
   Evening Phone _____

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PART B HEALTH HISTORY (check all that apply, and give approximate dates, if possible)

ALLERGIES

_____ Hayfever
_____ Poison Ivy, etc
_____ Insect Stings
_____ Penicillin
_____ Peanuts, Nuts
_____ **Other food or drugs

DISEASES OR HEALTH CONCERNS

_____ Chicken Pox
_____ Measles
_____ Convulsions
_____ Mumps
_____ Asthma
_____ Ear Infection
_____ Rheumatic Fever
_____ German Measles
_____ Diabetes
_____ Behavior
_____ Eczema
_____ Migraines
_____ Nosebleeds
_____ Braces
_____ Heart Murmer
_____ Contact Lenses
_____ Hives

**Specify _____
Other Health concerns or details of any above _____
_____
Operations/Serious Injuries (Date & Explanation) _____
_____
_____
Chronic/Returning Illness _____

Medications the camper will be taking during his/her session:

MEDICATION NAME DOSAGE REASON FOR MEDICATION

_____
_____
_____

****PLEASE SEND MEDICATION TO CAMP IN ORIGINAL CONTAINER WITH PRESCRIPTION LABEL ATTACHED**

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PART C IMMUNIZATION HISTORY (Please list dates as accurate as possible)

_____ DPT Series
_____ POLIO OPV (Sabin)
_____ MMR
_____ BOOSTER
_____ BOOSTER
_____ OTHER (please list) _____
_____ TETANUS BOOSTER
_____ TUBERCULIN TEST