



FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

# YMCA CAMPER HEALTH HISTORY FORM

**DO NOT MAIL**  
Please return form to camp  
on the day of check-in

Camper Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Parent/Guardian 1 Name: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Parent/Guardian 2 Name: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Family Email Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

**Immunization History** Are all immunizations up to date?  Yes  No Date of last tetanus shot (if known): \_\_\_\_/\_\_\_\_/\_\_\_\_

**Medical Information**

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of last physical exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medical Insurance Carrier: \_\_\_\_\_ Policy and/or group #: \_\_\_\_\_

**Past or Present (please check). If YES for asterisk \* items, must have a Doctor's Authorization completed (reverse side)**

Currently under Dr. care* <input type="checkbox"/> Yes <input type="checkbox"/> No	ADD/ADHD <input type="checkbox"/> Yes <input type="checkbox"/> No	Head Lice (recent) <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart defect/disease* <input type="checkbox"/> Yes <input type="checkbox"/> No	Autism <input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No
Recent hospitalization* <input type="checkbox"/> Yes <input type="checkbox"/> No	Asperger's Syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No	Measles <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma* <input type="checkbox"/> Yes <input type="checkbox"/> No	Bedwetting <input type="checkbox"/> Yes <input type="checkbox"/> No	German Measles <input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures* <input type="checkbox"/> Yes <input type="checkbox"/> No	Sleepwalking <input type="checkbox"/> Yes <input type="checkbox"/> No	Other diseases/conditions <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes* <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No	

For each  Yes, please explain: \_\_\_\_\_

<b>Allergies:</b> Bee Stings <input type="checkbox"/> Yes <input type="checkbox"/> No require Epipen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Food Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No List _____	Poison Oak/Ivy <input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No
Other insect/animals <input type="checkbox"/> Yes <input type="checkbox"/> No List _____	Any airborne allergies <input type="checkbox"/> Yes <input type="checkbox"/> No List _____	Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No List _____

**Dietary Restrictions?**  Yes  No

Any reason to restrict full activity including swimming, long hikes, strenuous physical games?  Yes  No

Any current mental, or psychological conditions requiring special consideration or restrictions?  Yes  No

For each  Yes, please explain: \_\_\_\_\_

**Current medications:** to be continued at camp: *(use additional pages if necessary)*

Med Name, Dosage \_\_\_\_\_ (Circle frequency) Breakfast, Lunch, Dinner, Bedtime, As needed, Other time \_\_\_\_\_

Med Name, Dosage \_\_\_\_\_ (Circle frequency) Breakfast, Lunch, Dinner, Bedtime, As needed, Other time \_\_\_\_\_

Med Name, Dosage \_\_\_\_\_ (Circle frequency) Breakfast, Lunch, Dinner, Bedtime, As needed, Other time \_\_\_\_\_

Inhalers or Epipens brought to camp? List what for and instructions \_\_\_\_\_

Other Medication Instructions for Health Care Staff: \_\_\_\_\_

**Non-Prescription Medications** I authorize the following medications or generic equivalent to be administered as needed:

Cough/Sore Throat Drops  Yes  No | Metamucil  Yes  No | Pepto Bismol  Yes  No | Cough Syrup  Yes  No

Acetaminophen (Tylenol)  Yes  No | Benadryl  Yes  No | Ibuprofen (Advil)  Yes  No | Hydrocortisone  Yes  No

**Waiver of Liability:** 1. I acknowledge that (i) I have read this document, (ii) I have inspected the YMCA facilities and equipment, (iii) I accept them as being safe and reasonably suited for the purposes intended and (iv) I voluntarily sign this document. 2. Except for YMCA's gross negligence or willful misconduct I release the YMCA, its directors, officers, employees and volunteers (collectively "Releasees") from all liability to me or the above said minor, for any loss or damage to property or injury or death to person, whether said damage or injury results from conditions arising upon the YMCA facilities or arising out of or in connection with YMCA programs or activities. YMCA shall not be liable for any damages arising from any act or neglect of any other member, occupant or user of the YMCA premises or participant in YMCA programs or activities. I agree that the above said minor assumes full responsibility for, and risk of, bodily injury, death or property damage except caused or due to the gross negligence or willful misconduct of the YMCA. 3. I agree not to sue Releasees for any loss, damage, injury or death described above and except for YMCA's gross negligence or willful misconduct, I will indemnify, protect, defend and hold harmless the YMCA and its Releasees from and against any and all claims and/or damages, liens, judgments, penalties, attorneys' and consultants' fees, expenses and/or liabilities arising out of, involving, or in connection with, the YMCA membership, use of YMCA facilities and/or participation in YMCA programs by me, the above said minor or any other person. If any action or proceeding is brought against YMCA by reason of any of the foregoing matters, I shall upon notice defend the same at my expense by counsel reasonably satisfactory to YMCA and YMCA shall cooperate with me in such defense. YMCA need not have first paid any such claim in order to be defended or indemnified. 4. I do hereby authorize the YMCA as agent for the undersigned, to consent with respect to said minor, to any x-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under general or special supervision of, any physician and surgeon licensed under the provisions of the California Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of the physician or at the hospital. I understand that the YMCA is not responsible for costs incurred for medical care. 5. The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of any groups of people other than in your own household. YMCA of San Diego County ("YMCA") has put in place preventative measures suggested by the Centers for Disease Control and Federal, State, and Local Government to reduce the spread of COVID-19; however, YMCA cannot guarantee that you or your child will not become infected with COVID-19. Further, attending YMCA facilities, programs or childcare could increase your family's risk, your risk, and your child's risk of contracting COVID-19. By signing this agreement, I acknowledge the highly contagious nature of COVID-19 and voluntarily assume the risk that my child and I along with my family may be exposed to or infected by COVID-19 by attending YMCA facilities, programs or childcare and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at YMCA facilities, programs or childcare may result from the actions, omissions, or negligence of myself and others, including, but not limited to, YMCA employees, volunteers, and program participants and their families I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to my child or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child or my family may experience or incur in connection with my child's attendance at YMCA or participation in YMCA programming ("Claims"). On my behalf, and on behalf of my family and children, I hereby release, covenant not to sue, discharge, and hold harmless YMCA, its employees, agents, and representatives, of and from any and all Claims, including all liabilities, claims, actions, suits, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of YMCA, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any YMCA program.

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Photographic Waiver/consent:** I give my permission to the YMCA of San Diego County to use my picture or other likeness, or a picture or other likeness of any of my children in the YMCA's general publicity and campaign materials.

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**THIS SECTION TO BE COMPLETED IF CURRENTLY UNDER DOCTOR'S CARE OR \*ASTERISK-HEALTH CONDITION IS CHECKED ON FRONT OF THIS FORM.**

**Note:** A Doctor's written authorization is only required if the camper has a history of Asthma, Heart Defect/Disease, Seizures, Diabetes, has been recently hospitalized, or is currently under a Doctor's care. If so, complete this section.

**Health Examination by Licensed Physician**

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_\_\_

Parent's name: \_\_\_\_\_

Because of this camper's medical history, we have asked that your written authorization be provided prior to their attendance at YMCA Camp. Please realize that camp is held at either mountain (4300 feet elevation) or oceanfront settings. The programs are very active with strenuous hiking, games, swimming, surfing, and camp activities. Your careful consideration is appreciated.

I have examined the child named on this form within the past two years. Date examined: \_\_\_/\_\_\_/\_\_\_

After examination and my review of his/her health history, it is my opinion that this person is physically able to engage in camp activities, except as noted below.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood pressure: \_\_\_\_\_

Is the applicant under the care of a physician for any conditions?  Yes  No Please explain: \_\_\_\_\_

Any specific activities to be encouraged or limited by physician's advice? \_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions? \_\_\_\_\_

Any treatment or medications to be continued at camp (please give specific dosages)? \_\_\_\_\_

Any allergies? (Food, drugs, plants, insects, etc): \_\_\_\_\_

Additional health information: \_\_\_\_\_

Licensed physician signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of form completion: \_\_\_/\_\_\_/\_\_\_ By: \_\_\_\_\_

**YMCA Overnight Camps - Marston | Surf | Raintree**  
PO Box 2440 Julian, CA 92036  
T 760 765 0642  
E camp@ymca.org W <http://www.ymcasd.org/camp>