Camper Last Name:	Session # / dates :	*Office use only* *Unit:*

Camp Westwind Programs 2009 Health History

Target Due Date: Friday, May 22nd

$25 fee per camper if received later than 3 weeks before registered session

Please type or print clearly, using a **ballpoint** pen (no felt pens, please). **Date form completed:** _______________

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history (first three pages) must be filled out by parents/guardians of minors or adults themselves. An updated health form is required annually. Page four must be completed by a licensed medical personnel **or** proof of a physical within the last 24 months must be attached.

Camper's Name ____ Birth Date ____________ Age _____ ❑ Male ❑ Female

Address ____ City __________________ State ______ Zip _________________

Parent or Legal Guardian's Name ____

Day Phone (_____)_________________Evening Phone (_____)________________Cell Phone (_____)_______________

Second Parent or Legal Guardian's Name ____

Day Phone (_____)_________________Evening Phone (_____)________________Cell Phone (_____)_______________

In case of emergency, if neither parent/guardian is available, whom should we contact? The child must be able to be released to this person.

Required Contact Name ___________________________________ Home Phone (_____)____________________________

Relation to Camper _____________________________________ Cell Phone (_____)____________________________

Health History: Check all applicable boxes and provide dates of condition(s). Attach extra sheets with additional information and/or protocols for treatments as necessary.

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

- ❑ Heart defect/disease ________________________________
- ❑ Therapy/Counseling ________________________________
- ❑ Asthma ________________________________
- ❑ ADD/ADHD ________________________________
- ❑ Diabetes ________________________________
- ❑ Mumps ________________________________
- ❑ Bedwetting ________________________________
- ❑ Sleepwalking ________________________________
- ❑ Back problems ________________________________
- ❑ Mononucleosis ________________________________
- ❑ Wears glasses/contacts ________________________________
- ❑ Head injury ________________________________
- ❑ Eating disorder ________________________________
- ❑ Use an orthodontic appliance ________________________________
- ❑ Surgeries or recent illnesses ________________________________
- ❑ Recent head lice ________________________________
- ❑ Convulsions/seizures ________________________________
- ❑ Chicken pox ________________________________
- ❑ Psychiatric treatment ________________________________
- ❑ Ear Infections ________________________________
- ❑ Hypertension/high blood pressure ________________________________
- ❑ Measles ________________________________
- ❑ Bleeding/clotting disorder ________________________________
- ❑ Skin conditions (e.g., itching, rash, acne) ________________________________
- ❑ Joint problems (e.g., knees, ankles) ________________________________
- ❑ Problems with diarrhea/constipation ________________________________
- ❑ Frequent headaches ________________________________
- ❑ Unconsciousness/passed out ________________________________
- ❑ Chest pain during or after exercise ________________________________
- ❑ Hepatitis A, B or C ________________________________
- ❑ Chronic or recurring illnesses________________________________
- ❑ Other (explain)________________________________

URGENT

Allergies: Be specific where applicable and describe reaction.

❑ Food (specify) ______________________________

❑ Penicillin ______________________________

❑ Other drugs ______________________________

❑ Hay fever______________________________

❑ Insect stings/bites______________________ Has child been stung by a bee? ❑ Yes ❑ No

❑ Other ______________________________

Restrictions: Dietary

❑ Does not eat red meat ❑ Does not eat poultry ❑ Does not eat dairy products

❑ Does not eat pork ❑ Does not eat eggs ❑ other (describe) ______________

❑ Gluten-free ❑ Does not eat seafood ______________

Explain any restriction to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

____

____

Immunizations: Please provide date of most recent vaccinations (vaccinations are not required to attend camp, but records are helpful to camp staff).

❑ Whooping Cough ____________ ❑ Tetanus ____________ ❑ Chicken Pox ____________

❑ Mumps ____________ ❑ Polio ____________ ❑ Diphtheria ____________

❑ Rubella ____________ ❑ Measles ____________ ❑ TD (tetanus/diphtheria)____________

❑ Hepatitis B ____________ ❑ Haemophilus influenza B ________ ❑ Other ____________

Date of last TB Mantoux Test____________ Result: ❑ Positive ❑ Negative

Use this space to provide any information which the camp should be aware of about the camper's behavior and physical, emotional, or mental health. (attach a separate page or contact camp offices directly if needed).

____

____

____

Medications: List all medications (including over-the-counter or nonprescription drugs taken routinely) that you are sending to camp. Medications must be in **original containers** with specific instructions for dispensing. Send enough medication to last the entire time at camp. The camper's name MUST be on the container. Medications sent to camp without any written instructions will not be administered to the camper. Attach additional pages as needed.

❑ This person takes NO medications on a routine basis **AND** NO medications have been sent to camp with this person.

❑ This person takes medications as follows:

Medication ______________________ used for ______________________

Amount/dosage ______________________ when taken ______________________

Medication ______________________ used for ______________________

Amount/dosage ______________________ when taken ______________________

Medication ______________________ used for ______________________

Amount/dosage ______________________ when taken ______________________

Identify any medication taken during the school year that participant does/may not take during the summer: ______________

____

____

Treatment:
YWCA Camp Westwind has medically standard procedures for dealing with typical health complaints. Treatments are typically what you would administer yourself using over-the-counter medications. The following is a list of routine medications that we have available at camp (when available we use the generic form of the name brands listed). Please indicate by each, if your camper may or may not be given these medications in dosages recommended for his/her age should the need arise. Persistent conditions, or those needing a physician's care, will be referred to the parent/guardian.

YES	NO		YES	NO	
❑	❑	Sunburn relief spray (Solarcaine, Bactine, Aloe)	❑	❑	Ibuprofen
❑	❑	Antiseptic ointments (Bacitricin, Neosporin)	❑	❑	Tylenol
❑	❑	Ear drops (for water in ears, wax build-up)	❑	❑	Cough drops
❑	❑	Cough syrup (Robitussin, Vicks, Dimetapp)	❑	❑	Decongestant (Sudafed)
❑	❑	Anti-emesis (controls vomiting)	❑	❑	Antihistamine (Benadryl)
❑	❑	Sore throat spray (Chloraseptic)	❑	❑	Burn gel (for minor burns)
❑	❑	Milk of Magnesia (for constipation)	❑	❑	Antacids (Tums, Maalox)
❑	❑	Anti-diarrheal (Kaopectate, Imodium AD)	❑	❑	Sting-ease (for insect bites)
❑	❑	Calamine/caladryl lotion (for insect bites, poison oak reaction)			

Female Campers Only: If your camper has not started menstruating and begins at camp, what is your preference for explaining, teaching, and talking with your daughter?

____

____

Insurance Information: If you carry family medical insurance, please complete this section:
Name of Main Policy Holder ____
Policy or Group No. ____________________________ Name of Carrier ____________________
Name of Doctor ______________________________ Phone (_______)____________________

Please read the statement below, sign and date.

This health history is correct and updated within the last 3 months. In a medical emergency, I understand that every effort will be made to contact a parent or guardian. If he or she cannot be reached, I give permission to the physician selected by YWCA personnel to secure and administer proper treatment, including hospitalization, for the above-named youth. I understand that I am responsible for any expenses that may be incurred in providing medical treatment to the above-named youth. I give permission for the health care manager or his/her designee to administer the medications that I have listed and/or approved on this form.

I understand and certify that my child's (family's) participation in YWCA Programs and its activities is completely voluntary and I have familiarized myself with the camp's program and activities in which my child (family) will be participating. I recognize that certain hazards and dangers are inherent in camp events and programs and particularly, but not limited to, the activities of horseback riding, ocean dipping, hiking, boating, swimming, bicycling, team sports and low elements challenge course. I acknowledge that although the YWCA has taken safety measures to minimize the risk of injury to camp participants, the YWCA cannot insure nor guarantee that the participants, equipment, premises and/or activities will be free of hazards, accidents and/or injuries. I hereby accept any and all responsibility for, and assume the risk of any and all injury to my person or dependent children, which might arise directly or indirectly as a result of, and or participation in a YWCA activity. I hereby expressly release, discharge and hold harmless from any liability whatsoever the YWCA of Portland, expressly including, but not limited to, the Board of Directors of the YWCA of Portland, except for injuries caused intentionally, or by willful misconduct.

I further recognize and have instructed my child (family) in the importance of knowing and abiding by the camp rules, regulations and procedures for the safety of camp participants. I certify my parental rights have not been terminated and that I have the plain authority to execute this permission. I have read and understand the refund, transfer and balance policies for the YWCA Camp Westwind and/or Westwind in the City programs and I agree to abide by all policies in regards to my or my child's camp registration.

Picture Authorization: I authorize the YWCA of Portland to have and use photographs, still and moving, of my child or myself as may be needed for its records or public relations projects. I certify that I am familiar with the contents of this release, that I have read and understand the same and that it is my intention by signing this release that the same be binding not only to me, but my heirs, administrators, executors, successors and assigns.

X **Signature of Parent/Guardian/Staff** ________________________________ **Date** __________

Parent/Guardian/Staff Printed Name ____

SIGNATURES REQUIRED

If for religious reason you cannot sign this, contact the camp for a legal waiver that must be signed for attendance.

<CAMPERS WILL NOT BE ALLOWED AT CAMP WITHOUT A COMPLETE/CURRENT FORM>

ACA accreditation requirements specify that a new exam is not necessary for camp attendance, but proof of an exam within the last 24 months **is required**.

The following form is the preferred proof, if signed by a Licensed Medical Personnel, but we will also accept documentation from your Licensed Medical Personnel specifying the results of a physical within the last 24 months.

Health Care Recommendations by Licensed Medical Personnel

I examined [ ] on [ ]
(camper's name) (date)

BP ________ Weight ________ Height ________

In my opinion, the above applicant ❑ **is** ❑ **is not** able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

____

Recommendations and Restrictions at Camp
Treatment to be continued at camp:

____

Medications to be administered at camp:
(name, dosage, frequency)

____

Medically-prescribed meal plan or dietary restrictions:

____

Known allergies:

____

Description of any limitation or restriction on camp activities:

____

Additional information for health care staff at the camp:

____

Signature of Licensed Medical Personnel: ______________________

Name (print clearly please) ______________________ Title ______________

Address ____

Phone(s) ______________________ DATE: ______________

For camp use only

Date Screened ______________ Time ________am / pm

Meds received: ____

Updates/additions to health history noted ____ Yes ____ No ____ None required

Current health needs identified: ______________________________

Observational notes: ______________________________________