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Kitaki Health History Form

This form must be filled out completely and signed by camper's parent/guardian and camper or adult staff member by April 15th or six weeks prior to session.

Return to: YMCA Camp Kitaki
6000 Cornhusker Hwy.
Lincoln, NE 68507
OR FAX TO (402) 434-9226

Camper's Name:____
LAST FIRST M.I.

Birthdate:___/___/___ Age:___

CAMP SESSION # ________

Please circle: MALE FEMALE

Parents/Guardian(s):____

Home Address:____ Phone:_____-_____-_______
STREET & NUMBER CITY/STATE ZIP

Business Phone : ______-_______-__________ Cell Phone:_____-_____-_________

Emergency Contact (other than parent):______________________________ Relation to camper:_____________

Home Address:____ Phone:_____-_____-_______
STREET & NUMBER CITY/STATE ZIP

Business Phone: _______-______-___________ Cell Phone:_____-_____-________

Do you carry medical/dental insurance? £No £Yes Carrier name: ______________________ Policy # : ______________________

GENERAL MEDICAL HISTORY (Explain "yes" answers below):

Has/does the participant:

		Yes	No
1.	Had any recent injury, illness or infectious disease?	£	£
2.	Have a chronic or recurring illness/condition?	£	£
3.	Ever had surgery?	£	£
4.	Ever had seizures?	£	£
5.	Have any skin problems?	£	£
6.	Have diabetes?	£	£
7.	Have asthma?	£	£
8.	Have problems with sleepwalking?	£	£
9.	If female, have an abnormal menstrual history?	£	£
10.	Ever had professional help for emotional difficulties?	£	£

Please explain any "yes" answers, noting the number of the question (or attach additional paper if necessary): ______________________________
____

HEALTH HISTORY:	**Yes**	**No**	**Date**
Frequent ear infections	£	£	_____
Heart defect/disease	£	£	_____
Bleeding/clotting disorders	£	£	_____
Hypertension	£	£	_____
Mononucleosis	£	£	_____
Diseases:			
Chicken Pox	£	£	_____
Measles/German Measles	£	£	_____
Mumps	£	£	_____
Hepatitis	£	£	_____
Allergies:			
Hay Fever	£	£	_____
Insect Stings	£	£	_____
Penicillin	£	£	_____
Other Drugs	£	£	_____

Other:____
____
____

Name of Dentist/Orthodontist: ________________________Phone #:_______________
Name of Family Physician:___________________________Phone #:_______________

***RESTRICTIONS**
Explain any restrictions to activities (e.g. what cannot be done, what adaptations or limitations are necessary):____
____

Special Dietary Restrictions £No £Yes *If yes, please attach information*
Additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware:________________________________
____
____

IMMUNIZATIONS: Please give date for most recent immunization, or write **"All Current"**.

Vaccine	**Date**	**Vaccine**	**Date**
DPT	_____	Rubella	_____
TD (Tetanus/diptheria)	_____	Homophiles influenza B	_____
Tetanus	_____	Hepatitis	_____
Polio	_____	Date of last TB Mantoux test	_____
Measles	_____	Result: __________	

MEDICATIONS Please list all medications, including non-prescription drugs, taken routinely. See parent handbook for instructions if bringing medications to camp.

£ This person takes no medications on a routine basis
£ This person takes medications as follows:
____
____
____

I give permission for camp staff to administer non-prescription medications as needed:
£ **Yes,** with the following exceptions: ____________
____
£ **No,** I do not give permission

IMPORTANT—THIS BOX MUST BE COMPLETED AND SIGNED *BY PARENT AND CAMPER* FOR ATTENDANCE

This health history is correct as far as I know and the person herein described has permission to engage in all prescribed camp activities except as noted. Under Nebraska Law, an equine professional is not liable for an injury to or the death of a participant in equine activities from the inherent risks of equine activities pursuant to the Nebraska Equine Activity Statute. Authorization for Treatment: I hereby give permission to the medical personnel selected by the Camp to order X-rays, routine tests, treatment, and necessary transportation for me/or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp to secure and administer treatment, including hospitalization, for my child named above. I understand the YMCA does not carry health and accident insurance and that I, as Guardian, will be responsible for any bills incurred. I also give permission for YMCA Camp Kitaki to transport my child off the camp property for the purpose of medical care and program activities. Camp Kitaki has my permission to use any photographs or videos of my child in promotional material. The completed forms may be photocopied for trips out of camp.

X Signature of Parent/Guardian or staff ____ Date:____________

*I also understand and agree with the information provided and to abide with the restrictions placed on my camp activities.

X Signature of minor camper ____ Date:____________

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Health Care Recommendations by Licensed Medical Personnel (Optional, but encouraged)

I have examined ______________________________ Date of last examination:____________________
Participant Name

Blood Pressure:________________ Weight:______________ Height:______________

In my opinion, the above named is £able / £not able to participate in an active camp program.

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

____

____

Current treatment at the time of examination includes:

____

____

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

____

____

Medications to be administered at camp:

____

____

Any medically prescribed meal plan or dietary restrictions, including any know food allergies:

____

____

Known allergies:

____

____

Description of any limitations or restriction on camp activities:

____

____

Additional information for the health care staff at camp:

____

____

Signature of Licensed Medical Personnel____

Printed______________________________ Title______________________________________

Address____

Phone____ Date________________________

FOR CAMP USE ONLY

Is all of the information current? **YES** **NO** **Explain:** ______________________

Is camper well enough to attend camp? **YES** **NO** **Explain:** ______________________

Has camper been seen by a doctor within 2 weeks? **NO** **YES** **Explain:** ______________________

Does the camper have any medications **YES** **NO** **(If yes, meds must be checked in to health specialist)**

Screened ___/___/___ *Check-In* OR *Time*__________ *am/pm* By ______________________________