

# YMCA CAMP WATCHAUG HEALTH HISTORY

**A completed health form is mandatory to attend camp. If your child has medical insurance, a copy of their card MUST be attached to this form. Mail or return to the Camp Registrar at the Westerly-Pawcatuck YMCA.**

Attn: Camp Registrar, 95 High Street, Westerly, RI 02891

Camper Name:		Gender:
Date of Birth:	Guardian:	Relationship:
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Emergency Contact:	Phone:	

**Important: If your child will need to take medications OR over-the-counter medicine while at camp an additional MEDICATION FORM must be completed and returned with this Health History Form. Forms can be found online, in your parent packet or at the Westerly-Pawcatuck YMCA**

\_\_\_ May participate in ALL camp activities  
 \_\_\_ May participate except for: \_\_\_\_\_

Current Medical, Mental or Psychological Condition pertinent to routine care of camper including any current treatment/care:  
 \_\_\_\_\_

Please describe any past medical treatment that this camper has received:  
 \_\_\_\_\_

Is this camper currently on any medications      Yes       No   
*(If YES, the Camper Medication Form must be completed)*

Does this camper have allergies?      Yes       No   
 Explain: \_\_\_\_\_

Is this camper on a special diet?      Yes       No   
 Explain: \_\_\_\_\_

This camper is current on all of the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>
Pertussis	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus Date: _____					

Print Name of Camper's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

This health history is correct so far as I know and the person herein can engage in all prescribed camp activities, except as noted by me. I give the certified staff permission use First Aid 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, anesthesia or surgery for my child as named above.

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