

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.

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 _____ 2. Name _____
Day Phone _____ Day Phone _____
Evening Phone _____ Evening Phone _____

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

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

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

PART D INSURANCE INFORMATION

DO YOU HAVE: _____ TITLE XIX _____ MEDICAID _____ NO INSURANCE COVERAGE

PLEASE LIST YOUR CARD NUMBER _____

*** PLEASE ATTACH A COPY OF BOTH SIDES OF YOUR INSURANCE CARD OR TITLE XIX CARD ***

If you have other insurance, please write name and address of insurance company _____

Is this coverage through: _____ Group/Father Employer _____ Group/Mother Employer
_____ Individual Policy _____ Other _____

Policy Number _____ Group Number _____

If you have secondary coverage, please provide this information:

INSURANCE COMPANY _____ POLICY NUMBER _____

ADDRESS _____

POLICY OWNER _____ GROUP NUMBER _____

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I authorize Spirit Lake Medical Center or Lakes Family Practice and associated physicians to release to the Medicare carriers or the insurance carrier listed above, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts the assignment on all future claims. I understand that I am financially responsible for all charges incurred.

PARENT'S AUTHORIZATION

I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physicians selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. Camp Foster YMCA will make every attempt to notify you before making a doctor's appointment or an emergency room visit for your child while they are in our care. All minor medical needs will be cared for by the on-site Health Director without notification to parents.

Camp Foster YMCA has my permission to use any photographs of my child in promotional material.

Signature - Parent/Guardian _____ Date _____

PART E MEDICAL EXAMINATION

*** The Medical Examination section must be completed by a licensed physician before attending camp. If a camper has had a general examination for any other reason within the past 24 months, a copy of that health record can be attached.

HGT _____ WGT _____ B.P. _____ EYES _____ GLASSES _____ EARS _____ NOSE _____

THROAT _____ TEETH _____ SKIN _____ POSTURE/SPINE _____ HEART _____ LUNGS _____

HERNIA _____ ABDOMEN _____ EXTREMITIES _____

ALLERGIES (Specify) _____

FEMALES: MENSTRUAL HISTORY NORMAL _____ SPECIAL CONSIDERATIONS _____

RESTRICTIONS/RECOMMENDATIONS WHILE AT CAMP _____

SPECIAL DIET (Specify) _____ SWIMMING/DIVING _____

STRENOUS ACTIVITY _____ OTHER _____

I HAVE EXAMINED THE PERSON DESCRIBED AND HAVE REVIEWED HIS/HER HEALTH HISTORY. IT IS MY OPINION THAT HE/SHE IS PHYSICALLY ABLE TO ENGAGE IN CAMP ACTIVITIES, EXCEPT AS NOTED.

PHYSICIAN SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

Thank you for taking the time to complete this form, helping us to ensure a healthy stay for your child while at Camp Foster YMCA.

YMCA Mission: To put Christian principles into practice through programs that build a healthy spirit, mind and body for all.

Camp Foster YMCA is committed to instilling values – Respect, Responsibility, Honesty, Caring & Fairness