YMCA Youth Health History Form

Information on this form is not part of the acceptance process, but is gathered to assist us in identifying appropriate care.

Name ____ Birth date _____/_____/_____ Sex ______ Age ________

Home Address ______________________ City ___________ State _____ Zip ________ Home Number ___________

1st Parent or Guardian _____________________ Relationship ___________ Daytime Phone Number ____________

2nd Parent or Guardian _____________________ Relationship ___________ Daytime Phone Number ____________

If those listed above cannot be reached in case of an emergency, notify:

Name _________________________ Relationship ______________ Phone __________ Other __________

Address ____ City ______ State _________ Zip __________

Health History:

(Check, give approximate dates)

_____ *Frequent ear infections* ______________
_____ *Heart defect/disease* ______________
_____ *Convulsions* ______________
_____ *Diabetes* ______________
_____ *Bleeding/clotting disorders* __________
_____ *Hypertension* ______________
_____ *Mononucleosis* ______________

Diseases

_____ *Chicken pox* ______________
_____ *Measles* ______________
_____ *German Measles* ______________
_____ *Mumps* ______________

Allergies

_____ *Hay Fever*
_____ *Ivy Poisoning*
_____ *Insect Stings*
_____ *Bee Stings*
_____ *Penicillin*
_____ *Other Drugs* ______________
_____ *Asthma*
_____ *Other (Please List)*
____

FOR FEMALE:

Has this person menstruated? ______________
If not, has she been told about it? ____________
If so, is her menstrual history normal? _________
Special Consideration ______________________

Medical Information

Operations or serious injuries & date: ______________________________________

Chronic or recurring illness or medical condition ______________________________

Activities encouraged or limited by physician ________________________________

Dietary restrictions ____

Allergies ____

Current medications (must be sent with instructions) _____________________________

Other diseases ____

Name of dentist/orthodontist ___________________________ phone ____________

Name of family physician ____________________________ phone ____________

Do you carry family medical/hospital insurance? ___Yes ___No

If so, Carrier ___________________________ Policy or Group # ______________

Suggestions on health related information for program personnel: ___________________

____

Please note: The section below MUST be filled out completely OR we must have an attached photocopy of immunization records to complete registration process.

Vaccines	Year of basic immunization	Year of last booster	Vaccines	Year of basic immunization	Year of last booster
DPT			Tuberculin test given		
Oral Polio			(HIB)		
Injectable Polio			Hepatitis B		
Measles			Tetanus		
Mumps			Other		
Rubella					

IMPORTANT – THIS BOX MUST BE COMPLETED FOR CAMP ATTENDANCE

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed school age child care and day camp activities except as noted.

Authorization for Treatment:

I hereby give permission to the medical personnel selected by the program director 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 that I cannot be reached in an emergency, I hereby give permission to the physician selected by the program director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips out of camp.

Signature of parent or guardian ______________________________ Date __________

*If for religious reasons, you cannot sign this, then the program director must be contacted and a written and signed statement must be on maintained file with this registration form stating the circumstances.