

**Health History Record of:** \_\_\_\_\_

**All information contained in this section will be kept confidential and only shared with essential staff members**

**Emergency Contact Information**

Please give the name and number of someone other than parent or guardian who can be reached in an emergency in the event that no one can be reached at the above numbers.

Name \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_

Parent's Name \_\_\_\_\_ Parent's Phone Number \_\_\_\_\_

Insurance Information	
Medical Insurance Co. _____	
Cardholder's Name _____	Doctor's Name _____
Policy Number _____	Doctor's Phone # _____

The following information is requested so that the camp can better meet the physical, intellectual, and emotional needs of the camper.

Is the camper having any of the problems listed below?	Yes	No		Yes	No
Hay fever, asthma, or wheezing			Trouble with passing urine or bowel movements		
Eczema or frequent skin rashes			Shortness of breath		
Convulsions/seizures			Speech problems		
Heart Trouble			Menstrual problems		
Diabetes			Dental problems		
Frequent colds, sore throats, ear aches (4 or more per year)			Other		

Please explain any problem areas identified above including any current infectious diseases:

If female, has she been told about menstruation (answer if appropriate) yes \_\_\_\_\_ no \_\_\_\_\_

Has she menstruated (answer if appropriate) yes \_\_\_\_\_ no \_\_\_\_\_

Operations or Injuries

Explain any special health, behavioral, or emotional considerations. Special conditions to be watched for such as ALLERGIES (reactions to food, penicillin or other drugs, bee stings), bedwetting, fainting, sleep walking, etc. (If you child is allergic to peanuts, please note if the allergy is ingested or airborne.)

Should the camper's activity be restricted in any way because of any physical limitation or illness? Yes \_\_\_\_\_ No \_\_\_\_ If yes, please explain degree of restriction.

Medical History continued for: \_\_\_\_\_

Medications needed or used (including psychiatric)			Currently being Given	
Kind	Frequency	Dosage	Yes	No

IMMUNIZATIONS:

Are camper's immunizations up to date? \_\_\_\_\_ Date of most recent tetanus? \_\_\_\_\_

The following medications are part of the MCYC standing orders. Please check the medications you would **NOT** want your child to receive.

Medication	Common Brand Name	<b><u>NO</u></b>	Common conditions treated with this medication
Acetaminophen	Tylenol		Pain, headache, stomach ache, fever
Aloe			Burns, sunburns
Analgesic gel	Oragel, Anbesol		Toothache, canker sores
Analgesic Ointment	Solarcaine		Cuts, scrapes, burns, sunburns
Antacid-ranitidine	Zantac		Heartburn
Anti-fungal	Desinex, Nizoral		Jock itch, athlete's foot
Antibiotic ointment	Neosporin		Cuts, scrapes
Anti-diarrheal	Immodium AD		Diarrhea
Anti-gas	Mylanta, Tums		Stomach ache
Antihistamine	Benadryl, Dimetap, Claritin		Itching, congestion, allergies
Cold/Allergy Combinations	Tylenol Cold, etc.		Cough, congestion, runny nose, pain
Dextromethorphan/guafinesin	Robitussin DM		Cough
Hydrocortisone cream	Cortaid		Rashes
Ibuprofen	Motrin, Advil		Pain, headache, stomach ache, fever, inflammation
Menstrual combination	Midol		Menstrual pain, cramps
Milk of magnesia			Constipation
Naproxen/sodium	Aleve		Pain, headache, stomach ache, fever, inflammation
Rash ointments	Desitin, A & D, Vaseline		Heat rash, chapped and dry skin

I hereby give permission to medical personnel selected by the camp staff to order X-rays, routine tests, and treatment for my child, \_\_\_\_\_. In the event of an emergency and I cannot be reached, I hereby give permission to the physician selected by MCYC to hospitalize, secure proper treatment, order injections and/or anesthesia and/or surgery to the camper listed above. I further authorize the release of the medical information contained on the Health History Record to appropriate medical personnel and/or the health coverage insurance company. In addition, I hereby release MCYC, its employees or agents from liability associated with participation in camp activities. I understand that if I do not have medical insurance, I, as the parent or guardian, will be responsible for any medical expenses in the event of a sickness and/or injury. I understand that there are risks involved in participating in recreation activities and other programs related to participation in youth functions.

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name