Session: ___________ Session Dates: ___________________ Fax: 612-465-0559 Phone: 612-822-2267	 YMCA Camp Meongyn HEALTH HISTORY FORM Summer 2010	**Return to:** YMCA Camp Menogyn 2125 E. Hennepin Avenue Suite 100 Minneapolis, MN 55413-1763 Fax: 612-465-0559

This **Health History** form is required for all YMCA Camp Menogyn participants. **A new form must be completed each year of participation.** The information requested is intended to help us in the event of an emergency. This information will alert us to potential problems, special needs or accommodations that might be required. By Program Policy, all of the information is confidential and made available only to Administrative Staff,

Contact Information:

Camper Name: ____ Birth Date: ____________ Gender: ________
Last First Middle

Home address ____
Street Address City State Zip

First Parent/Guardian: ____ Relationship to Camper: ______________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

Second Parent/Guardian: ______________________________________ Relationship to Camper: ______________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

Emergency Contact: ____ Relationship to Camper ______________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

The following must be completed for attendance:

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted. I authorize the camp and its staff to give reasonable first aid and administer over-the-counter medications as necessary.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as May be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as “personal representatives” for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person’s ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child’s health status.

In the event 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 the person named above. This completed form May be photocopied for trips out of camp.

I also give permission for my child to enter Canada with YMCA Camp Menogyn, if the trip involves such travel.

Signature of Parent/Guardian or adult camper/staffer: ____Date____________

Waiver of Liability and Release of Indemnification:

I understand that although the Young Men’s Christian Association of Minneapolis and Camp Menogyn have taken reasonable steps to provide my child with appropriate training, equipment and skilled staff for his/her outdoor experience, I acknowledge that some inherent risks cannot be eliminated without destroying the unique character of this activity. Such risks include, but are not limited to those associated with canoeing, portaging, backpacking, cooking over an open fire, encountering wild animals and other components of wilderness travel.

I also understand that me/my minor child will be transported to and from the activity by a properly licensed and qualified YMCA Camp Menogyn staff, volunteer, or contracted driver in a YMCA Camp Menogyn owned or leased vehicle.

Aware of these risks and willing to assume them, I hereby waive release and agree to hold harmless the YMCA, Camp Menogyn, and their representatives and successors for all claims or liabilities of any kind arising out of me/my minor child’s participation in this camping experience. I have read the descriptions of the session, understand the requirements for participation, and give my child permission to participate. I assume and accept full responsibility for my/his/her participation.

I understand that the YMCA of Metropolitan Minneapolis and Camp Menogyn assume no responsibility for injuries or illnesses which me/my minor child May sustain as a result of my/his/her physical condition or resulting from participation in any camp activities or experiences. I expressly acknowledge on behalf of myself and my minor child and heirs that I assume the risk for any and all injuries and illness which May result from me/my minor child’s participation in these activities. I hereby release and discharge the YMCA of Metropolitan Minneapolis and Camp Menogyn, its directors, officers, employees and volunteers from any and all claims for accidents, injuries, death, loss or damage which me/my minor child May suffer as a result of participating in these activities.

Signature of Parent/Guardian or adult camper/staffer: ____ **Date:** ____________

Camper Name: ________________________________ **Session:** ______________________

Session Dates: ________________

Insurance Information

Is the participant covered by family medical/hospital insurance? 5 Yes 5 No

If so, indicate carrier or plan name: ____ Group/Policy #: _____________________________

☐ Photocopy of front and back of health insurance card must be attached to this form.

Allergies

☐ No known allergies.

☐ This camper is allergic to: 5 Food 5 Medicine 5 The environment (insect stings, iodine, etc.) 5 Other

(Please describe below what the camper is allergic to and the reaction seen.)

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Medications

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. **Keep it in the original packaging/bottle** that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.

☐ This person takes NO medications on a routine basis.

☐ This person takes medications as follows **(Please list below the medication, dosage, frequency and reason.)**:

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Please list any non-prescription medications and ointments I **do not** want given to my child: ____

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Health History

	Yes	No
1. Ever been hospitalized?	☐	☐
2. Ever had surgery	☐	☐
3. Have recurrent/chronic illnesses?	☐	☐
4. Had a recent injury?	☐	☐
5. Had asthma/wheezing/shortness of breath?	☐	☐
6. Have diabetes?	☐	☐
7. Had seizures/epilepsy?	☐	☐
8. Had headaches?	☐	☐
9. Wear glasses, contacts, or protective eyewear?	☐	☐
10. Had fainting or dizziness?	☐	☐
11. Passed out/had chest pain during exercise	☐	☐
12. Frequent ear infections	☐	☐
13. Had mononucleosis during the past 12 months?	☐	☐
14. Have problems with falling asleep/sleepwalking?	☐	☐
15. Have a history of bedwetting?	☐	☐
16. Ever had back/joint problems?	☐	☐
17. Have problems with diarrhea/constipation?	☐	☐
18. Have any skin problems?	☐	☐
19. Traveled outside the country in the past 9 months?	☐	☐
20. High blood pressure	☐	☐
21. Been a carrier of a communicable disease (eg MRSA, VRE, Tuberculosis, etc)	☐	☐

Please explain any question you responded "Yes": ____

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(For Female) Has this person menstruated?______ If yes, is her menstrual history normal?______ If not, has she been told about if?_______

Camper Name: ________________________________ **Session:** ________________________

Diet & Nutrition

Session Dates: __________________

☐ This camper has no dietary restrictions
☐ This camper the following dietary restrictions. Include self-imposed restrictions, e.g. vegetarian. **(Please describe)**:

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Mental, Emotional & Social Health

Has the camper:

		Yes	No
1.	Ever been treated for attention deficit disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)?	☐	☐
2.	Ever been treated for a psychiatric diagnosis such as depression, OCD, ODD, panic/anxiety disorder?	☐	☐
3.	Ever been treated for emotional or behavioral difficulties or an eating disorder?	☐	☐
4.	During the past 12 months, seen a professional to address mental/emotional health concerns?	☐	☐
5.	Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)	☐	☐

Please explain "Yes" answers:

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Is there anything else the Menogyn trail counselor should know about your camper that would be helpful in providing the best wilderness experience this summer (previous camp experiences, school experience, living situation, difficult transition in their life, e.g. divorce, death in the family, etc)?

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What have we forgotten to ask?

Please provide in the space below any additional information about the camper's health that you think important or that May affect the camper's ability to fully participate in the camp program. **Attach additional information if needed.**

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The following people are NOT authorized or allowed to pick up my child from the YMCA Camp Menogyn bus stop or from YMCA Camp Menogyn:

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If for religious reasons, you cannot sign this form, please contact the camp for a legal waiver that must be signed for attendance.

Camper Name: ________________________________

Session: ____________________

Session Dates: ______________

Camp Menogyn Health Professional Notes

For Camp use only

Pre-Trip Check In:

Date________________ Screened by_______________________

Temp_____________ Throat______________ Feet_____________

Allergies: ____

____

Medications: ____

____

Comments: ____

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Post-Trip Check In:

Date________________ Screened by_______________________

Temp_____________ Throat______________ Feet_____________

Comments: ____

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Pre-Trip Check In:

Date________________ Screened by_______________________

Temp_____________ Throat______________ Feet_____________

Allergies: ____

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Medications: ____

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Comments: ____

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Post-Trip Check In:

Date________________ Screened by_______________________

Temp_____________ Throat______________ Feet_____________

Comments: ____

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