

# Warner-Tully YMCA Health Form



Personal Information - Health History - Immunization History

**NOTE: This Form to be Filled in by Parent or Guardian and MUST Sign Where Noted!**

Session Attending: 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_

## Personal Information:

Camper's Name \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Home Phone \_\_\_\_\_ With whom does child live? \_\_\_\_\_  
Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_  
Father's Employer and Phone # \_\_\_\_\_  
Father's Cell Phone # \_\_\_\_\_ Mother's Cell Phone # \_\_\_\_\_  
Mother's Employer and Phone # \_\_\_\_\_  
Insurance Carrier \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_ Phone # \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Emergency Phone # \_\_\_\_\_

## Health History:

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_ Dentist/Orthodontist \_\_\_\_\_ Phone \_\_\_\_\_  
Disability or Chronic Illness \_\_\_\_\_  
Currently Under Care of Physician for: \_\_\_\_\_ Current Treatment for This Condition: \_\_\_\_\_  
Medications to be Administered at Camp: \_\_\_\_\_  
Recommendations or Restrictions While at Camp: \_\_\_\_\_  
Dietary Restrictions \_\_\_\_\_ Food Allergies \_\_\_\_\_

(Please Check Any That Currently Apply):  
Frequent Ear Infections \_\_\_\_\_ Asthma \_\_\_\_\_ Insect Allergies/Anaphylaxis \_\_\_\_\_ Seizures \_\_\_\_\_  
Heart Defect/Disease \_\_\_\_\_ Ivy Poisoning \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Bed Wetting \_\_\_\_\_  
Diabetes \_\_\_\_\_ Penicillin \_\_\_\_\_ Measles \_\_\_\_\_ Head Lice (4wks prior to camp) \_\_\_\_\_  
Mumps \_\_\_\_\_

## Immunization History:

Vaccines:	Date of Basic Immunization	Date of Last Booster
Diphtheria/Pertussis/Tetanus	_____	_____
Polio	_____	_____
Measles (Rubella)/ Mumps	_____	_____

## General Information and Required Guardian SIGNATURE

-Health and Immunization Histories must be completed, signed and dated by camper (parent or guardian if a minor) within 12 months of camp attendance.  
-Our Healthcare Staff will make every effort to contact you if your child has need for out-of-camp health care. We do not contact you if your child is seen in the Infirmary for routine problems (skinned knees, headache etc.) that do not require a physician referral. The decision to consult you for in-camp health care is determined on a case-by-case basis by Healthcare Staff. Please attach a letter to this Health Form if you want us to follow a practice other than what is described.  
-My signature below releases Warner-Tully YMCA Camp, including its trustees, employees and agents from my physical injury, including death, or illness while at camp. I will assume the risk associated therewith, whether known or unknown to me at this time. This release is also intended to include all claims of my family, estate, heirs, personal representatives, or assigns.

### Please Read and SIGN Below

-The health information contained on this form is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted. I give Warner-Tully Camp authorization to share any health information deemed necessary with applicable camp staff that will be involved directly.  
**Emergency Authorization** I hereby give permission to the medical personnel selected by Warner-Tully Camp to order ambulance transport, order X-rays, routine tests, and treatment for the person named above. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Warner-Tully Camp to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the person named above.

\_\_\_\_\_  
Parent/Guardian or Adult Camper/Staff Member

\_\_\_\_\_  
Date



Warner-Tully YMCA Camp Physician's Form

**IMPORTANT NOTE: THIS SIDE TO BE FILLED OUT BY  
LICENSED PHYSICIAN UNLESS SCHOOL PHYSICAL  
CAN BE PROVIDED THAT IS WITHIN LAST 2 YEARS.**

**Physician or Nurse MUST Sign Where Noted!**

Session Attending: 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ Mini-Camp \_\_\_\_\_

Camper's Name \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_

**Medical Exam by Licensed Physician – Must be Completed Within 24 Months of Camp Attendance**

I have examined the above named camper on: \_\_\_\_\_  
*Date Examined*

In my opinion, the above camper's health status (does \_\_\_\_\_) (does not \_\_\_\_\_) preclude his/her participation in an active camp program.

Additional Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Licensed Physician's Signature** \_\_\_\_\_

By: \_\_\_\_\_  
*\*Please Initial if completed by nurse or PA*

Phone # \_\_\_\_\_

Date Form Completed \_\_\_\_\_

**Warner-Tully YMCA Camp  
267 YMCA Place  
Vicksburg, MS 39180  
601-638-1071  
601-634-0918 fax**