

PARENT FORM



Mail/Fax this form to:
445 Athens Y Camp Road
Clarkesville, GA 30523
Fax: 706-754-3868
Phone: 706-754-8528
ycamp@windstream.net

Dates will attend camp _____ to _____

Camper Name: _____

Birth Date: _____ Age at camp: _____

To parent(s)/guardian(s): Please follow the instructions below.

- 1) Complete all pages of this form.
- 2) Send the original, signed "Parent Form" to the camp.
- 3) Complete the top of "Physician Form" and provide a copy of the "Parent Form" and the "Physician Form" to your child's health care provider for review and completion.
- 4) After it has been completed and signed by your child's health care provider, return "Physician Form" to the camp.

Camper Home Address: _____

Parent/Guardian with legal custody to be contacted in case of illness of injury:

Name: _____ Relationship to Camper: _____ Phone: _____

Home Address (if different from above): _____

Second parent/guardian or other emergency contact:

Name: _____ Relationship to Camper: _____ Phone: _____

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name: _____ Relationship to Camper: _____ Phone: _____

Allergies: _____ No known allergies _____ This camper is allergic to: (list all including food, medication, the environment, and any other)

Diet/Nutrition: _____ Eats a regular diet _____ Eats a vegetarian diet _____ Has special food needs (please describe)

Restrictions: _____ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions
_____ I feel the camper can participate with the following restrictions or adaptations (please describe)

Medical Insurance Information:

This camper is covered by family medical/hospital insurance: _____ Yes _____ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company: _____ Policy Number: _____

Subscriber: _____ Insurance Company Phone: _____

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person describes has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status."

Signature of custodial parent/guardian: _____

Date: _____ Relationship to Camper: _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

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Camper Name: _____

Birth Date: _____

Immunization History:

Please check immunizations your child has received. Starred (*) immunizations must be current. Copies of immunization forms from health-care providers or state or local governments are acceptable and can be attached to this form.

____ Diphtheria, tetanus, pertussis* (DTaP) or (TdaP) ____ Tetanus booster* (dT) or (TdaP)
____ Mumps, measles, rubella* (MMR) ____ Polio* (IPV)
____ Haemophilus influenzae type B (HIB) ____ Pneumococcal (PCV)
____ Hepatitis B ____ Hepatitis A
____ Varicella (chicken pox) ____ Meningococcal meningitis (MCV4)
 Had chicken pox: ____ Date: ____

Tuberculosis (TB) Test:

Date: _____ Negative: ____ Positive: ____

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____

Medication:

____ This camper will not take any daily medication while attending camp.
____ This camper will take the following daily medication(s) while at camp. (This includes vitamins and natural remedies)
List all medications: (include name of medication, when it is given, amount/dose given)

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers in the space below.

| | | | |
|-----------------------------------|------------------|--|------------------|
| Has/does the camper... | | | |
| Ever been hospitalized? | ____ Yes ____ No | Had fainting or dizziness? | ____ Yes ____ No |
| Ever had surgery? | ____ Yes ____ No | Passed out/had chest pain during exercise? | ____ Yes ____ No |
| Have recurrent/chronic illnesses? | ____ Yes ____ No | Had mononucleosis during the past 12 months? | ____ Yes ____ No |
| Had a recent infectious disease? | ____ Yes ____ No | Have problems with period/menstruation? | ____ Yes ____ No |
| Had a recent injury? | ____ Yes ____ No | Have problems falling asleep/sleepwalking? | ____ Yes ____ No |
| Had asthma/shortness of breath? | ____ Yes ____ No | Ever had back/joint problems? | ____ Yes ____ No |
| Have diabetes? | ____ Yes ____ No | Have a history of bedwetting? | ____ Yes ____ No |
| Had seizures? | ____ Yes ____ No | Have problems with diarrhea/constipation? | ____ Yes ____ No |
| Had headaches? | ____ Yes ____ No | Have any skin problems? | ____ Yes ____ No |
| Wear any eyewear? | ____ Yes ____ No | Traveled outside the country in the past 9 mos.? | ____ Yes ____ No |

Please explain "Yes" answers in the space below:

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the camper...
Ever been treated for ADD or AD/HD? ____ Yes ____ No
Ever been treated for emotional or behavioral difficulties? ____ Yes ____ No
Ever been treated for an eating disorder? ____ Yes ____ No
During the past 12 months, seen a professional to address mental/emotional health concerns? ____ Yes ____ No
Had a significant life event that continues to affect the camper's life? ____ Yes ____ No
(history of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.)

Please explain "Yes" answers in the space below:

Health Care Providers:

Name of camper's primary doctor(s): _____ Phone: _____

Name of dentist(s): _____ Phone: _____

Name of orthodontist(s): _____ Phone: _____

What have we forgotten to ask? Please provide below. Attach additional information if necessary.