

**YMCA CAMP CARSON**  
**2010 HEALTH EXAMINATION FORM**

**THIS SIDE TO BE COMPLETED BY PARENT OR GUARDIAN AND SIGNED PRIOR TO REVIEW BY A PHYSICIAN.**

**This form (NO SUBSTITUTIONS) must be received by May 21<sup>st</sup> for medical staff review. In accordance with Indiana State Law, if this form is not completed and returned your child will be unable to attend YMCA Camp Carson.**

**PLEASE RETURN TO:** YMCA Camp Carson, 2034 Outer Lake Road, Princeton, Indiana 47670

**CAMPER NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**CAMPER ADDRESS:** \_\_\_\_\_ **HOME PHONE** \_\_\_\_\_

**CAMP SESSION(S) DATE(S):** \_\_\_\_\_

**MOM NAME** \_\_\_\_\_ **MOM CELL** \_\_\_\_\_ **MOM (WORK)** \_\_\_\_\_

**DAD NAME** \_\_\_\_\_ **DAD CELL** \_\_\_\_\_ **DAD (WORK)** \_\_\_\_\_

If parents cannot be reached in case of emergency, notify: \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Phone (H) \_\_\_\_\_ (Work or Cell) \_\_\_\_\_ Address \_\_\_\_\_

Health & Accident Insurance Company \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policy Holder \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

**HEALTH HISTORY: Please check (√) and attach a separate statement regarding potential problem areas:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Recurring Strep Throat                 | <input type="checkbox"/> Heart Disorder                 | <input type="checkbox"/> Serious Injuries           |
| <input type="checkbox"/> Frequent Ear Infections                | <input type="checkbox"/> Sleep Walking                  | <input type="checkbox"/> Severe Headaches/Migraines |
| <input type="checkbox"/> Chronic Cough                          | <input type="checkbox"/> Bed Wetting                    | <input type="checkbox"/> Hepatitis                  |
| <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> Fainting                       | <input type="checkbox"/> Infectious Mononucleosis   |
| <input type="checkbox"/> Chronic Constipation                   | <input type="checkbox"/> Seizures                       | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Kidney Problem/Urinary Tract Infection | <input type="checkbox"/> ADD/ADHD Learning Disabilities | <input type="checkbox"/> Chicken Pox                |
|   |   | Other _____   |

Allergic Reactions: (Please give details)  
Insect Stings \_\_\_\_\_ Poison Ivy/Oak \_\_\_\_\_  
Drugs \_\_\_\_\_ Other \_\_\_\_\_

For female campers - Has your daughter menstruated?  Yes  No Has she been told about menstruation?  Yes  No

Has your child been evaluated or received treatment or counseling by a psychologist or physician for an emotional or behavioral problem, including hyperactivity? [ ] Yes [ ] No If so, on a separate statement, please help us understand how to effectively address these concerns.

**Are there other special concerns regarding your child's health or medical history? (Attach separate statement, if necessary)**

**NOTE:**

- **Please write or call the camp if your child is exposed to or has contracted any potentially serious communicable disease such as chickenpox, hepatitis, meningitis, etc. during the three weeks prior to camp attendance.**
- **Final acceptance is subject to review by the Medical Staff.**

*We are proud of our infirmary, which may be staffed by experienced registered and graduate nurses, nurse practitioners, or E.M.T.'s. YMCA Camp Carson has a physician on call 24 hours who is available for medical situations which require such attention or services. In the event of unforeseen circumstances, it is essential that the parent or guardian sign the following statement.*

**PARENT'S AUTHORIZATION:** This health history is accurate to the best of my knowledge and the child herein described has permission to engage in all camp activities except as noted by the examining physician and me.  
*I hereby give permission to the nurse or physician selected by the camp director to perform routine tests and treatment for the health of my child. In the event I cannot be reached in a life-threatening emergency, I hereby give permission to the physician selected by the camp director to appropriately manage the medical problem.*

**SIGNATURE OF PARENT OR GUARDIAN** \_\_\_\_\_ **Date** \_\_\_\_\_

**IMPORTANT: THIS FORM (NO SUBSTITUTIONS) MUST BE RECEIVED AT YMCA CAMP CARSON BY MAY 21, 2010**

## PHYSICAL EXAMINATION

To be completed and signed by a *licensed physician* within **12 months** prior to camper's arrival at camp for any camping session.  
**Return to YMCA Camp Carson, 2034 Outer Lake Road, Princeton, Indiana 47670 (812) 385-3597**

CAMPER NAME \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

THE OBJECTIVES OF THIS EXAMINATION ARE TO DETERMINE THAT THIS CHILD:

1. IS PHYSICALLY FIT TO ENGAGE IN STRENUOUS ACTIVITIES WITHOUT HARM TO HIMSELF/HERSELF OR OTHERS.
2. HAS NO SIGNIFICANT INFECTIOUS CONDITION THAT COULD BE TRANSMITTED TO OTHERS.
3. HAS NO EMOTIONAL OR PHYSICAL DISORDER THAT COULD NOT BE CARED FOR UNDER THE ROUTINE OPERATIONS AND PROGRAMS OF CAMP. (SOME SPECIAL CONDITIONS MAY BE HANDLED.)

**NOTE: Blood work and Urinalysis are NOT REQUIRED. However, if recent results of these tests are available, please provide information as it can be useful as baseline information should something arise during the camper's stay at camp.**

Hgt. \_\_\_\_\_ Wt. \_\_\_\_\_ B.P. \_\_\_\_\_ **Please note BLOOD PRESSURE is required.**

Date and results of MOST RECENT Hgb / Hct. (Not Required): \_\_\_\_\_ (if pubertal, within one year)

Urinalysis (Not Required) pH. \_\_\_\_\_ Protein \_\_\_\_\_ Sugar \_\_\_\_\_ (dip stick test acceptable)

Code: (√) Normal; (X) Abnormal (Explain)

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Skin _____   | <input type="checkbox"/> Chest _____       |
| <input type="checkbox"/> Eyes _____   | <input type="checkbox"/> Heart _____       |
| <input type="checkbox"/> Ears _____   | <input type="checkbox"/> Abdomen _____     |
| <input type="checkbox"/> Nose _____   | <input type="checkbox"/> Extremities _____ |
| <input type="checkbox"/> Throat _____ | <input type="checkbox"/> Spine _____       |
| <input type="checkbox"/> Teeth _____  | <input type="checkbox"/> Neurologic _____  |

Menstrual History: Regularity \_\_\_\_\_ Duration \_\_\_\_\_ Cramping \_\_\_\_\_

Recommendations and restrictions (diet, activity restrictions): \_\_\_\_\_

Allergies: \_\_\_\_\_

Does camper have chronic medical problems, emotional difficulties or behavioral issues that you are aware of? [ ] Yes [ ] No  
 If yes, please describe the condition. \_\_\_\_\_

No routine medications or nutritional supplements will be administered without documentation from the physician. Please list these: \_\_\_\_\_

To coincide with Indiana law for school enrollment, YMCA Camp Carson requires the following immunizations; five DPT, DTaP or DT doses (If fourth dose is after fourth birthday, fifth dose is not required.); four Polio vaccine doses (If third dose is after fourth birthday, fourth dose is not required.); and two MMR doses (first dose on/after first birthday) and three Hep B vaccines.

### IMMUNIZATIONS

DPT/DTaP					
DT/dT					
HIB					
Tetra					
Varivax					
BCG/Other					

*OPV					
*IPV					
MMR					
HEP B					
HEP A					

\*or other AAP/ACIP acceptable schedules using IPV

Date of most recent PPD (Mantoux) Test \_\_\_\_\_ Test results \_\_\_\_\_  
 (if indicated by the guidelines published in the most recent Center for Disease Control Redbook)

**MY SIGNATURE INDICATES** I have reviewed the Health History on the reverse side of this form as well as examined this patient on this date \_\_\_\_\_. **Exam Date must be within 12 months of arrival at Camp.**

**SIGNATURE OF PHYSICIAN** \_\_\_\_\_

**Phone #** \_\_\_\_\_ **Address** \_\_\_\_\_

**IMPORTANT: THIS FORM (NO SUBSTITUTIONS) MUST BE RECEIVED AT YMCA CAMP CARSON BY MAY 21, 2010**