

**CAMP HEALTH HISTORY & EXAMINATION FORM FOR CHILDREN, YOUTH & ADULTS**

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. This form, except for the "Health Recommendations of Licensed Medical Personnel," to be filled in by parents/guardians of minors or by adults themselves.

**MAIL TO: FAIRVIEW LAKE YMCA**  
**1035 Fairview Lake Road**  
**Newton, NJ 07860**  
**Tel: 973 383 9282**  
**Fax: 973 383 6386**



**Camper Details**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age at camp \_\_\_\_\_ Gender M / F  
Last First MI Circle One

**Contact Information**

Parent or Guardian Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Address \_\_\_\_\_  
Street Apt.# City State Zip

Home Phone ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Second Parent/Guardian or Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

*If not available in an emergency, notify: Name \_\_\_\_\_ Relationship \_\_\_\_\_*

Home Phone ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

**FOR ALL PARTICIPANTS**

**THIS MUST BE SIGNED OR YOU WILL NOT BE ABLE TO ATTEND CAMP**

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

**Emergency Authorization**

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted. **Permission to Treat:** I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.\*

Signature of parent/guardian or adult camper/staff \_\_\_\_\_ Date \_\_\_\_\_

**Please Note: Parents are also required to sign the bottom of page 4**





Camper's name \_\_\_\_\_  
 Last First

**Standard Over the Counter Medications** - The following over the counter medications are available in the health center. If your child requires daily medications, please send them in the original packaging. These medications can be administered by a Registered Nurse per label instructions by age and weight only if **Parent and Physician written permission** is on file in the Health Center.

Key: **PRN** (if needed) **PO** (taken by mouth) **Topical** (applied to skin) **Q** (every)

Drug Name	Route	Schedule & Indications	To be administered if needed Yes / No
Ibuprofen (e.g. Advil, Motrin)	By Mouth / PO (Chewable tabs, pills or liquid)	Q 6h as needed for pain or fever>__-F, cold symptoms, toothache, muscle aches	Yes or No
Acetaminophen (e.g. Tylenol)	By Mouth / PO (Chewable tabs, pills or liquid)	Q 4h as needed for pain or fever>__-F cold symptoms, toothache, muscle aches	Yes or No
Robitussin	By Mouth / PO (liquid)	Q 4h for coughs	Yes or No
Cough drops and Lozenges	By mouth (lozenges)	Q 2h as needed for coughs/sore throats	Yes or No
Diphenhydramine (e.g. Benadryl)	By Mouth / PO / Topical (pills, liquid, or spray)	Q 6h as needed for allergic reaction, hives, insect bites	Yes or No
Epinepherine	Injectable	Allergic reaction difficulty swallowing or breathing	Yes or No
Pseudoephedrine (e.g. Sudafed)	PO (Chewable tabs, pills or liquid)	Q 4h nasal/sinus congestion, hay fever, allergies Not more than 4 doses in 24 hours	Yes or No
Antacid (e.g. Mylanta, Tums, Pepto Bismal)	PO (pills or liquid)	For gas, heartburn, indigestion, upset stomach	Yes or No
Ivy Block and Tecnu	Topical (cream)	Q 6h for contact with poison ivy	Yes or No
Calagel, Calamine and Hydrocortisone	Apply Topically (cream or gel)	Q 4h for insect bites, rash, skin irritation	Yes or No
Bacitracin, First Aid Cream	Topical (ointment)	Q 4h for cuts, scrapes, signs of irritation	Yes or No
Cooling Gel and Aloe	Topical (cream or gel)	Q 4h for burns, sunburn, wind burn	Yes or No
Muscle Rub	Topical (cream)	Minor muscle strains or pains	Yes or No
Orasol, Ambesol and Abreva	Topical (cream or liquid)	Oral herpes, cold sores, toothache	Yes or No
Medicaine	Topical (liquid)	Apply once for insect stings	Yes or No
Nix	Topical (liquid)	For head lice	Yes or No

**REQUIRED - Licensed Physician's Signature** \_\_\_\_\_ License # \_\_\_\_\_  
 Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
 Date of form completion \_\_\_\_\_ by \_\_\_\_\_  
 Initial if completed by nurse or physician's assistant

**REQUIRED - Parental Permission for medications listed above** Please Note: Parents must also sign on Page 1  
 Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_