



# YMCA of Greater Westfield Camp Shepard Day Camp - Health Exam Form



\*\*\*TO BE FILLED OUT BY PARENT OR GUARDIAN – PLEASE PRINT\*\*\*

Camper's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Home Address \_\_\_\_\_

Business Address \_\_\_\_\_ Phone \_\_\_\_\_

Mother's Cell Phone \_\_\_\_\_ Father's Cell Phone \_\_\_\_\_

If not available in an emergency notify:

1. \_\_\_\_\_ Phone \_\_\_\_\_  
Name Address

2. \_\_\_\_\_ Phone \_\_\_\_\_  
Name Address

### Child Release Authorization:

List *name* and *phone* of any additional persons authorized to pick up child, not listed above:

\_\_\_\_\_  
 \_\_\_\_\_

**Medications:**

We strongly discourage administration of medications at Camp Shepard. However, if a camper must receive any medication while at Camp Shepard, an "Authorization to Administer Medication to a Camper" form must be completed for each medication. This form can be found at the front desk of the YMCA or online at [www.westfieldymca.org](http://www.westfieldymca.org), and is due one full week before the session begins. All medications must be turned in upon arrival to Camp Shepard.

**Health History (please check):**

Frequent Ear Infections _____	Chicken Pox _____	Hay Fever _____
Heart Defect/Disease _____	Measles _____	Poison Ivy _____
Convulsions _____	German Measles _____	Insect Sting Allergy _____
Diabetes _____	Mumps _____	Drug Allergy _____
Bleeding/Clotting Disorders _____	Asthma _____	Food Allergy _____

For each check, please explain: \_\_\_\_\_

Any specific activities to be encouraged? \_\_\_\_\_

Any specific activities to be restricted? \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Dentist/Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical/Hospital Insurance Carrier: \_\_\_\_\_ Policy/Group # \_\_\_\_\_

**IMPORTANT: PLEASE NOTIFY THE YMCA IF THIS CHILD IS EXPOSED TO ANY COMMUNICABLE DISEASE DURING THE THREE WEEKS PRIOR TO ATTENDANCE OR WHILE ATTENDING ANY YMCA PROGRAM.**

Parents Authorization: This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted by me and the examining physician. I give my permission for my child to be given simple first aid at the YMCA and to be transported to the hospital if "Y" personnel deem it necessary. I hereby give permission to the physician selected by the director to order x-rays, routine tests, and treatment for the health of my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the director to hospitalize, secure proper treatment for, and to order injection, and/or anesthesia, and/or surgery for my child as named above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*PLEASE TURN OVER\*\*\*

\*\*\***TO BE FILLED OUT BY PHYSICIAN – PLEASE PRINT**\*\*\*

**Immunization History:**

Required immunization must be determined locally. Please record the date (mo. & yr.) of basic immunizations and most recent booster doses.

Vaccine	Date Immunized	Date of Last Booster
Measles, Mumps & Rubella (MMR)	1	
	2	
Polio	1	
	2	
	3	
Diphtheria Tetanus Toxoids Pertussis DtaP/DTP/DT/Td (minimum of 4 doses)	1	
	2	
	3	
	4	
Hepatitis B		
Other		

Tuberculin test given \_\_\_\_\_ (most recent.)

**Medical Examination:**

To be filled out by licensed physician. This examination should be performed every 2 years. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Hgt. \_\_\_\_\_ Wt. \_\_\_\_\_ B.P. \_\_\_\_\_ Hct. Or Hgb. Test \_\_\_\_\_ Urinalysis \_\_\_\_\_

Code:	V-Satisfactory	X-Not Satisfactory (explain)	O-Not examined
Eyes _____	Lungs _____	Allergic: (Please specify)	
Glasses _____	Abdomen _____	_____	
Ears _____	Hernia _____	_____	
Nose _____	Extremities _____	General Appraisal:	
Throat _____	Spine _____	_____	
Heart _____	Skin _____	_____	

Current medications: \_\_\_\_\_

Recommendations and restrictions while in program:

Special diet \_\_\_\_\_  
 Swimming, diving \_\_\_\_\_  
 Strenuous activity \_\_\_\_\_  
 Other \_\_\_\_\_

I have examined the person herein described and have reviewed the health history. It is my opinion that this child is physically able to engage in program activities except as noted above.

\_\_\_\_\_  
Date Examining Physician

\_\_\_\_\_  
Phone Address

**Please return to:**  
**Bridget Daley, Camping & Outdoor Education Director**  
**YMCA of Greater Westfield, 67 Court Street, Westfield, MA 01085**