GLOW YMCA CAMP HOUGH

PARTICIPANT HEALTH FORM – TO BE COMPLETED BY PARENT/GUARDIAN

PLEASE NOTE THE NEED FOR PHYSICIAN'S SIGNATURES ON BOTH SIDES OF THIS FORM.

NOT ALL YMCA SUMMER PROGRAMS ADMINISTER MEDICATION, HOWEVER, IN THE EVENT OF AN EMERGENCY WE ASK THAT FAMILIES PROVIDE US THIS INFORMATION SO THAT WE CAN BEST CARE FOR YOUR CHILD.

Child Name:	Age:	Height:	Weight:
Guardian Name:	Phone 1:	Phone 2:	Phone 3:
Has your child been exposed to an infectious disease or had any major illness in the last month? ☐ No ☐ Yes			
If yes, Illness/Disease:		Symptoms:	
Is the child covered by any hospitalization/medical care policy? ☐ Yes ☐ No			
Insurance Company:			
Card Holder:		Policy/Group #:	

PROGRAM PARTICIPANT HEALTH FORM, CONT. – TO BE COMPLETED BY PHYSICIAN

CAMPER HEALTH HISTORY

Please Check All That Apply.

☐ Asthma	☐ Heart Defect/Disease	☐ Frequent Ear Infections	☐ Dental:
☐ Convulsions	☐ Bleeding/Clotting Disorder	☐ Neurological Disorders	☐ Other:
☐ Diabetes	☐ Hearing Problems	☐ ADD/ADHD	☐ Other:
☐ Emotional Disorder	☐ Vision Problems	☐ Illness:	☐ Other:

DIET/NUTRITION: LIST DIETARY RESTRICTIONS ☐EATS A REGULAR DIET

_____

_____

ALLERGIES: LIST ALL ALLERGIES AND REACTIONS ☐NO KNOWN ALLERGIES

_____

_____

ADMINISTRATION OF PRESCRIPTION MEDICATIONS TO CHILD

PLEASE COMPLETE WITH PATIENT'S **CURRENT/SUMMER** REGIMEN FOR BOTH SCHEDULED AND PRN MEDICATIONS.

DRUG NAME	ROUTE (PLEASE INDICATE PREFERRED FORMULATION)	DOSAGE	SCHEDULE & INDICATIONS (PLEASE CIRCLE ALL THAT APPLY)	HEALTHCARE PROVIDER ORDER (PLEASE CIRCLE ONE)
PHYSICIAN SIGNATURE 1 OF 2 (see reverse side of page):				**DATE:**

Individualized Standing Orders for Administration of Over-The-Counter Medication – To Be Completed by Physician

Not all YMCA Summer Programs administer medication or house medications. However, in the event of an emergency we ask that families provide us this information. The following medications may be available and will be administered at the discretion of the YMCA nurse/MAT/health care provider as indicated.

Child Name:		**Age:**	**Weight:**	**Height:**
Drug Name	**Route (please circle preferred formulation)**	**Dosage**	**Schedule & Indications (please circle all that apply)**	**Healthcare Provider Order (please circle)**
Insect Repellant	Topical	As per package instructions	As needed	**Yes No**
Antiseptic Ointment	Topical	As per package instructions	Minor wound care Other:	**Yes No**
Anti-itch Ointment	Topical	As per package instructions	Rashes insect bites Other:	**Yes No**
Anti-Sting Ointment	Topical	As per package instruction	Insect bites Other:	**Yes No**
Antibiotic Ointment	Topical	As per package instruction	Minor wound care Other:	**Yes No**
Sunburn Relief Ointment	Topical	As per package instructions	Sunburn Other:	**Yes No**
Ibuprofen	Oral	As per package instructions	Pain; swelling; fever Other:	**Yes No**
Acetaminophen	Oral	As per package instructions	Pain; swelling; fever Other:	**Yes No**
Anti-fungal Cream	Topical	As per package instructions	Athletes foot Other:	**Yes No**
Antacid/ Antiemetic	Oral	As per package instructions	Nausea; diarrhea Other:	**Yes No**
Swimmer's Ear Drops	Topical	As per package instructions	Ear pain after swimming Other:	**Yes No**
Eye Drops	Topical	As per package instructions	Eye irritation; allergies Other:	**Yes No**
Hydrocortisone 0.5%	Topical	As per package instructions	Rashes; insect bites; poison ivy Other:	**Yes No**
Cough Syrup	Oral	As per package instructions	Coughing Other:	**Yes No**
Laxative	Oral	As per package instructions	Constipation Other:	**Yes No**
Antihistamine	Oral or Topical	As per package instructions	Swelling Hives; allergic reaction; nasal congestion; Other:	**Yes No**
Anti-diarrhea	Oral	As per package instructions	Diarrhea Other:	**Yes No**
Lice Treatment	Topical	As per package instructions	Detection Other:	**Yes No**

Health Care Provider Name:		
Address:		
City:	State:	Zip:
License Number:	Phone:	Fax:
As requested by the patient and as mandated by New York State Department of Health, a dated and/or current copy of immunizations/shot records is attached. ___ Physician Initials		
Physician Signature 2 of 2:		**Date:**