STAR Camp Health History Form

Complete one form per child – PLEASE PRINT; all medication sent to camp must be given to Camp Nurse and labeled clearly with Doctor's instructions. Complete reverse side of this form.

YMCA
We build strong kids, strong families, strong communities.

Child's Name _____ ☐ M ☐ F Age_____ Birth Date _____

Address _____ Apt.____ City _____ Zip _____ Hm. Phone (____)_____

Child's Height _____ Child's Weight _____ School _____ Current Grade_____

Parent/Guardian Name _____ Parent/Guardian Name _____

Employer _____ Employer _____

Parent/Guardian daytime phone (_____)_____ Parent/Guardian daytime phone (_____)_____

Pager/cell phone (_____)_____ Pager/cell phone (_____)_____

INFORMATION REQUIRED BY STATE LAW

Health Insurance Co:

Policy Number:

Family Physician:

Address:

Phone:

Family Dentist:

Address:_____

Phone:_____

Tetanus Immunization Date:_____

HEALTH RECORD

(check applicable conditions or allergies)

☐ Ear Infections ☐ Convulsions ☐ Rheumatic Fever ☐ Diabetes
☐ Insect Stings ☐ Poison Oak ☐ Hay Fever ☐ Penicillin
☐ Behavior Problems:_____
Other: _____
Operations, serious injuries, diseases, restrictions on physical activity:

EMERGENCY INFORMATION

Authorized persons to be called in case of an emergency, when parents can not be reached:

Name	Phone	Relationship

CHILD RELEASE AUTHORIZATION

Persons AUTHORIZED to pick up child from the facility (Parents must be listed below):

Name	Phone	Relationship

Please list equipment needed such as wheelchair, braces, glasses, contact lenses, etc.:

PARENT/GUARDIAN AUTHORIZATION

This health history is correct, so far as I know, and the person herein has permission to engage in all prescribed program activities. I give permission to the physician selected by the San Mateo County Sheriff's Office (SMSO) or YMCA to order X-Rays, routine tests, and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the SMSO or YMCA to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child named above. Recognizing that the SMSO and YMCA will do its best to ensure a safe experience, I understand that certain dangers or accidents may occur. I hereby release the SMSO and YMCA from all responsibility and liability of any nature, including claims from injury, illness, death, loss or damage, resulting from my child's participation in program activities. Photos of my child may be used for promotional purposes. This form may be photocopied for use away from the main program site. I authorize the SMSO and YMCA staff to apply sunscreen to my child's exposed skin, on an as-needed basis.

Parent/Guardian Signature: _____ **Date:** _____

STAR Camp - Request for Medication and Physician's Instructions

Section 1: Physician's Instructions for Acute or Chronic Problem
If your child is under a doctor(s) care for an acute or chronic problem, your physician needs to know that the child will be away from home for several days. Please have physician give instructions in this space for care of child.

Section 2: Prescription Medication (The medication must be in its prescription container.) Please attach a separate sheet of paper if necessary.

Print Name of Child (Last, First)	**Sex** _____ **M** _____ **F**	**Birth Date**

I request that my child (named above) be assisted by an authorized person in taking prescribed medication (described below) at YMCA Camp Loma Mar / STAR Camp, in compliance with the program's policies and procedures.

Signature of custodial parent or guardian	**Date signed**	**Home Telephone** ( )

Medications

Description of prescribed medications shall be completed by child's physician

	Name of Medication 1.	**Name of Medication** 2.	**Name of Medication** 3.
Purpose of Medication			
Dosage Prescribed			
Time Schedule			
Dose form (liquid, tablet, etc.)			
Date of Prescription			
Length of Time Medication is Necessary			
Precautions, special instructions, possible adverse effects, or comments:			

To be Completed by Physician

Print Name of Physician:	**The above named child, for whom the above medication is prescribed, is under my care.**
Telephone Number:	**Signature of Physician:**
Address (street, city, state, and zip):	**Date Signed:**

Health History

If there has been any history of the following, please circle and explain where necessary:

Nose Bleeds	**Trouble w/ears**	**Heart Trouble**	**Convulsions**	**Asthma/Hay Fever**	**Bed Wetting**
Trouble w/ eyes	**Chronic Cough**	**Fainting**	**Shortness of Breath**	**Hyperactivity**	**Hives**

_____

_____

Food or other allergies?_____ Allergies to Sunscreen? _____