CAMP MAHACKENO & HAFADAY HEALTH FORM

TO BE COMPLETED BY A PARENT OR GUARDIAN

Physical Exams must be within past 2 years of the last day child will be at camp.

Office Use Only

Mahackeno / Hafaday
Camper / Staff

Name_____ Date of Birth _____ Phone_____
Address_____
Guardian 1 Name_____ Relationship _____ Work Phone _____ Cell Phone _____
Guardian 2 Name _____ Relationship _____Work Phone _____Cell Phone _____
Emergency Contact Name _____ Relationship _____ Phone Number _____

Medications, Allergies, Handicaps

Please list all medications that your child is taking. Campers may not be given any medications (prescription or over the counter) unless we have a camp Authorization of Medication Form. State law does not allow us to use the school form.

_____

Is there any medication that your child takes during the school year that they will not be taking this summer? _____
Does your child have an allergic reaction to Bees ☐ Medication ☐ Peanuts ☐ Other _____
What symptoms may occur in the case of an allergic reaction? _____
Does your child carry an Epi Pen? Yes☐ No ☐ If yes, two must be provided to the camp to stay at camp.

History of Medical Treatment, Problems and Disease: Please circle all areas that apply.

The Westport Weston Family Y requires background information on your child in order to provide licensed medical staff with pertinent information in case of emergency. (Please explain any "Yes" answers below). Has the camper now or in the past

Do you give permission for a camp staff member to apply sunblock to your child? If so, please send sunblock with them to camp. Yes☐ No ☐

1. Had any recent injury, illness or infectious disease? Yes☐ No☐
2. Have any chronic or reoccurring illness? Yes☐ No☐
3. Ever been hospitalized? Yes☐ No☐
4. Have frequent headaches? Yes☐ No☐
5. Ever had surgery? Yes☐ No☐
6. Ever had a head injury? Yes☐ No☐
7. Ever been knocked unconscious? Yes☐ No☐
8. Wear glasses, contacts or protective eye wear? Yes☐ No☐
9. Ever had frequent ear infections? Yes☐ No☐
10. Ever passed out during or after exercise? Yes☐ No☐
11. Ever been dizzy during or after exercise? Yes☐ No☐
12. Ever had seizures? Yes☐ No☐
13. Ever had chest pain during or after exercise? Yes☐ No☐
14. Ever had high blood pressure? Yes☐ No☐
15. Ever been diagnosed with a heart murmur? Yes☐ No☐
16. Ever had back problems? Yes☐ No☐
17. Ever had problems with joints? Yes☐ No☐
18. Have orthodontic appliance coming to camp? Yes☐ No☐
19. Have any skin problems? Yes☐ No☐
20. Have diabetes? Yes☐ No☐
21. Have asthma? Yes☐ No☐
22. Had mononucleosis within the past 12 months? Yes☐ No☐

Please use this space provided to give us any additional information on any "Yes" answers _____

_____

Does your child have any behavior, emotional, physical, psychological and mental health issues that the camp should be aware of, and are there any medications, treatments or special restrictions that the camp needs to be aware of for your child? _____

_____

Insurance information

Is the participant covered by family medical/ hospital insurance? Yes ☐ No ☐
Carrier or plan name _____ Group #_____ ID#_____
Name of insured _____ Relationship to camper/staff member _____

Permission to provide treatment or emergency care:

The health history herein is correct as far as I know. I accept full responsibility for the health and physical condition of the person herein described, and give my permission for him/her to engage in all Westport Weston Family Y sponsored activities, except as noted by me. I give the staff permission to apply sunscreen/lotion to my camper on an as-needed basis during the day at camp. In the event that I cannot be reached in an emergency, I hereby give my permission to the physician and staff selected by the Westport Weston Family Y to hospitalize, secure proper treatment or to order injections, anesthesia, or surgery for my child as named above. This completed form may be photocopied for trips out of camp.

Parent/Guardian signature: _____ Date: _____

TO BE COMPLETED BY A MEDICAL PRACTITIONER:

Date of Exam ___/___/___

* The camp will accept a copy of the school physical form to replace this side of the camp health form.

Child's name _____ Date of birth _____

_____ May participate in all camp activities

_____ May participate except for:

_____

Medical information pertinent to routine care and emergencies:

_____

Is this individual taking prescription or over the counter medication(s)? YES NO

If yes, indicate names of medication(s):_____

Does the individual have allergies? YES NO Explain: _____

Is the individual on a special diet? YES NO Explain: _____

Does the individual have special needs? YES NO Explain: _____

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate (PCV)		
Tetanus			Polio		

Comments: _____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's: City/Town _____ ST_____ Zip Code_____

_____
Signature of Physician, PA, APRN or RN

_____
Date Form Signed

_____
Telephone Number

Please return completed health forms to: the Westport Weston Family YMCA at 14 Allen Raymond Lane, Westport CT 06880