YMCA
CAMP SEA GULL
CAMP SEAFARER

Tracking Out Camp Seafarer Trip
Health History Form

Camper's Name:_____ Name Called:_____
First Middle Last

❑ Male ❑ Female Previous Sea Gull/Seafarer camper: ❑ No ❑ Yes_____
If Yes, how many years at camp?

Date of Birth ___ / _____ / _____ Age at Camp: _____**Years** _____ **Months** Grade___ Branch _____

Mother's Name: _____	Father's Name: _____
Home Phone: (_____) _____	Home Phone: (_____) _____
Work Phone: (_____) _____	Work Phone: (_____) _____
Cell Phone: (_____) _____	Cell Phone: (_____) _____

In the case of separation or divorce, both sets of information are required.

If neither parent can be reached, in case of emergency notify _____
Relationship _____Home Phone: (_____) _____
Work Phone: (_____)_____ ext. _____ Cell Phone: (_____)_____

HEALTH HISTORY: Please check ❑ and attach a separate statement regarding potential problem areas:

❑ Recurring Strep Throat ❑ Heart Disorder ❑ Serious Injuries ❑ Frequent Ear Infections
❑ Sleep Walking ❑ Severe Headaches/Migraines ❑ Chronic Cough ❑ Bed Wetting
❑ Hepatitis ❑ Asthma/Wheezing ❑ Fainting ❑ Infectious Mononucleosis
❑ Chronic Constipation ❑ Seizures ❑ Tuberculosis
❑ ADD/ADHD Learning Disabilities ❑ Kidney Problem/Urinary Tract Infection
❑ Chicken Pox – Date of Disease _____
❑ Other _____

Allergic Reactions: (Please give details)
Insect Stings _____ Poison Ivy/Oak _____
Drugs _____ Food _____
Other _____

Has your child been evaluated or received treatment or counseling by a psychologist or physician for an emotional or behavioral problem, including hyperactivity? ❑ No ❑ Yes If yes, on a separate statement, please help us understand how to effectively address these concerns. Are there other special concerns regarding your child's medical history? (attach a separate statement if necessary)

_____
_____
_____

NOTE:
- Please write or call the camp if your child is exposed to or has contracted any potentially serious communicable diseases (such as chicken pox, hepatitis, meningitis, etc.) during the three weeks prior to camp attendance.
- In order to complete the registration process, this form (no substitutions) must be received one week prior to program start date.
- Final acceptance is subject to review by the Camp Medical Committee, and the director reserves the right to rescind enrollment based upon recommendation of medical staff.

PERMISSION TO EXAMINE, PRESCRIBE MEDICATION AND TREAT: I hereby give permission to the registered nurse or physician selected by the camp director to perform routine tests and treatment for the health of my child. In the event of an emergency or other acute event where time will not allow me to be reached, or I cannot be reached, I hereby give permission for the camp physician to secure necessary consultative care for my child, including hospitalization, anesthesia, surgery and other medical treatment.

PERMISSION TO DISCLOSE INFORMATION: I agree to allow the camp physician or Health Clinic director to speak with the camp director and camp personnel living or working with my child, regarding any medications my child is taking, as well as specific medical or psychological conditions that may impact my child's daily living.

PERMISSION TO RELEASE RECORDS: I authorize the camp physician or Health Clinic director to release any health records related to my child as may be necessary for treatment, referral, billing, or insurance purposes.

Signature of Parent/Guardian _____ Date _____