

YMCA Camp Hi-Rock Medical Form For Staff 18 years and older

Please complete this form prior to beginning work.

Name: _____ Date of Birth: _____ Age: _____ Gender: _____

Home Address: _____ City: _____

State: _____ Country: _____ Zip: _____

Emergency Contact: Name: _____ Relation: _____

Home Phone: (____) _____ Work/Cell Phone: (____) _____

Primary Care Physician's Name: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Health Insurance Information: Please attach a photo of insurance card or form.

Does your health insurance company require notification prior to emergency care or appointment with non-primary care physician? _____

Dates of operations or serious illness: _____

Disability or chronic or recurring illness: _____

Do you have any allergies Y / N; If yes please list with reaction: _____

Please read, understand, and sign the following release, indemnity, and authorization for treatment.

I consent to the aforementioned staff member participating in any YMCA Camp Hi-Rock programs or activities, either on or off camp property. I acknowledge that participation in camp activities has inherent risk. I, the undersigned parent or guardian, assume that risk on behalf of my child and will indemnify and hold harmless the camp/Central Connecticut Coast YMCA from and against all claims and demands on account of, or in any way from, any accidental occurrence. In the event that my child should need further medical treatment while at camp, I give the camp medical staff permission to order x-rays, routine tests, treatments that may require hospitalization, and necessary transportation. I give the camp medical staff permission to administer medication or treatment prescribed by the camp's local physician should this become necessary. I understand that the camp medical staff may be unable to contact me at the time when medical treatment is necessary and therefore grant permission for them to seek and administer such treatment and medication prior to contacting me for further permission. I authorize payment of medical benefits to the health care provider for any necessary services and the release of any medical or other information necessary to process claims for visits incurred. In addition, I give the camp medical staff permission to administer other over-the-counter medications they deem necessary. I confirm that, to the best of my knowledge, my child is not allergic to any medications other than those listed above. I further grant any pictures or video taken of my child at camp may be used for publicity and promotional purposes. This completed form may be photocopied. I have read the above and understand its meaning.

Printed name of Staff Member _____

Signature of Staff Member: _____

Date: _____

Name: _____ DOB: _____

Medical History: To be completed by a Physician. A Certificate of Immunization is to be attached. This form must be fully completed before sending to camp. This is the only form approved by the local Board of Health. It meets local regulation requirements.

Vaccine	date #1	date #2	date #3	date #4	date #5	date #6
MMR (measles, mumps, rubella)						
DTP (diphtheria, tetanus, pertussis)						
Td/Tdap (if more than ten years have lapsed since last DTP)						
Other: _____						
Other: _____						
Other: _____						

Please list any allergies including reaction and treatment (drug, food and environmental): _____

Please specify any dietary restrictions: _____

Current medications (YOU MUST COMPLETE THE MEDICATION ADMINISTRATION RELEASE FORM): _____

Medical history/conditions that may affect the camper's activities while at camp: _____

Activities encouraged or limited by physician: _____

TB: In high-risk group? High: PPD date: _____ Result: _____

Low

Physician's Examination: Blood Pressure: ____/____ Pulse: _____ Height: _____ Weight: _____

Physical Development: _____

I have completed the above and have examined the individual. In my opinion, the condition of the person listed above does not preclude his/her participation in an active camp program. I have screened the individual for active signs of tuberculosis.

Licensed Physician's Signature: _____ Date: _____

Address: _____ Phone: (____) _____

Please note: According to Commonwealth of Massachusetts Law, we may not admit any child to camp without this completed medical form. The front page must be completed by the camper's parent/guardian including the signed authorization for treatment. This side must be completed by a physician. The camper must have been examined by a physician within 24 months prior to his/her stay at camp. All campers must have a record of immunizations meeting the Massachusetts immunization requirements for children attending recreational camps. For more information, please contact your physician or the camp office.