YMCA Camp Bernie
Camper Health History

Please return this form to YMCA Camp Bernie **by June 1st**

- **Upload** to Campwise Account or
- **Email** to info@campbernieymca.org or
- **Fax** to 908-832-9078 or
- **Mail** to 327 Turkey Top Rd. Port Murray, NJ 07865

Session(s) camper will attend camp _____ (Sessions) □ Day □ Overnight

Camper Name: _____ (First Middle Last)

□ Male □ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp _____ (Age)

Instructions for parent/guardians:

- *Please complete pages 1, 2 and 3. A Universal Health Form **MAY NOT** be used in place of this form.*
- *A copy of your child's immunization record obtained from your doctor may be included in place of the top of page 2.*
- *The bottom section of page 3 must be completed and signed or stamped by your camper's doctor FOR OVERNIGHT CAMPERS ONLY. Day campers may skip the last section on page 3.*
- *Please upload a pdf of all 3 pages to your child's Campwise Account. If you are unable to do so, please email your documents to info@campbernieymca.org or choose another method listed on the upper left of this form.*

Camper Home Address _____ (Street Address City State Zip)

Parent/Guardian with legal custody to be contacted in case of illness or injury:

Name _____ Relationship to camper _____ Preferred Phone: (___)_____

Home Address _____ (if different from above) (Street Address City State Zip)

Email _____

Second parent/guardian or other emergency contact:

Name _____ Relationship to camper _____ Preferred Phone: (___)_____

Email _____

Additional contact in event parent(s)/guardian(s) cannot be reached:

Name _____ Relationship to camper _____ Preferred Phone: (___)_____

Allergies: □ No known allergies □ This camper is allergic to □ Food □ Medicine □Environment □ Other

Please describe below what the camper is allergic to and the reactions seen. Please also list all allergies on the camper's Campwise account.

Diet/Nutrition: □ This camper eats a regular diet □ This camper east a regular vegetarian diet
□ This camper has special food needs *(Please describe below)*

Restrictions: □ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
□ I have reviewed the program and activities of the camp and feel the camper can participate with some restrictions, about which I will contact the camp to discuss.

Medical Insurance Information:

This camper is covered by family medical/hospital insurance □ Yes □ No

Insurance Company _____ Policy Number _____

Subscriber _____ Subscriber Birth Date _____ Insurance Company Phone (___)_____

Please upload a copy of the front and back of your camper's health insurance card to your Campwise account.

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. I give permission to the physician selected by the camp to order x-rays, routing tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent _____ Date _____

Printed Name _____ Relationship to Camper_____

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Camper Name _____
First Middle Last

Birth Date _____
Month/Day/Year

Immunization History *Please provide the month and year for each immunization. Starred (*) immunizations must be current. Copies of immunization forms from health care providers or state or local government are acceptable; please upload a pdf to your Campwise account under "Immunization Record".*

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria; tetanus; pertussis * (DTaP) or (TdaP)						
Tetanus booster * (dT) or (TdaP)						
Mumps, measles, rubella * (MMR)						
Polio * (IPV)						
Haemophilus Influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitus A						
Varicella (chicken pox) □ Had chicken pox Date _____						
Meningococcal meningitis (MCV4)						
COVID-19						

Tuberculosis (TB) test	Date	□ Negative □ Positive

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent _____ Date _____

Printed Name _____ Relationship to Camper_____

Medication: □ This camper will not take any daily medications while attending camp.
□ This camper will take the following medication(s) while at camp:

**Note: "Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. All medication must be turned in to the Camp Nurse during check-in in its original packaging/container with labels which show the camper's name and how the medication should be given. Campers may keep inhalers or epi-pens on their persons or with their counselors if necessary. The Camp Nurse will not administer medication other than epi-pen via syringe. Camper must be able to administer such medication independently. Provide enough of each medication to last the entire time the camper will be at camp.*

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			□ Breakfast □ Lunch □ Dinner □ Bedtime □ Other Time: _____		
			□ Breakfast □ Lunch □ Dinner □ Bedtime □ Other Time: _____		
			□ Breakfast □ Lunch □ Dinner □ Bedtime □ Other Time: _____		

The following non-prescription medications may be stocked in the camp Wellness Center and are used on an as needed basis to manage illness and injury.
Cross out those the camper should not be given.

Acetaminophen (Tylenol)
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore throat spray
Lice shampoo or cream (Nix or Elimite)
Calamine lotion
Laxatives for constipation (Ex-Lax)
Ibuprofen (Advil, Motrin)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Bismuth subsalicylate for diarrhea (Kaopectate, Pepto Bismol)
Aloe

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Camper Name _____
First Middle Last

Birth Date _____
Month/Day/Year

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

1. Ever been hospitalized?..... ☐ Yes ☐ No
2. Ever had surgery?..... ☐ Yes ☐ No
3. Have recurrent/chronic illnesses?..... ☐ Yes ☐ No
4. Had a recent infectious disease?..... ☐ Yes ☐ No
5. Had a recent injury..... ☐ Yes ☐ No
6. Ever had back/joint problems..... ☐ Yes ☐ No
7. Have diabetes?..... ☐ Yes ☐ No
8. Had seizures?..... ☐ Yes ☐ No
9. Had headaches?..... ☐ Yes ☐ No
10. Have any skin problems?..... ☐ Yes ☐ No
11. Had fainting or dizziness?..... ☐ Yes ☐ No
12. Passed out/had chest pain during exercise?..... ☐ Yes ☐ No
13. Had mononucleosis ("mono") during the past 12 months?. ☐ Yes ☐ No
14. If female, have problems with periods/menstruation?..... ☐ Yes ☐ No
15. Have problems with falling asleep/sleep walking?..... ☐ Yes ☐ No
16. Had asthma/wheezing/shortness of breath?..... ☐ Yes ☐ No
17. Have a history of bedwetting?..... ☐ Yes ☐ No
18. Have problems with diarrhea/constipation?..... ☐ Yes ☐ No
19. Wear glasses/contacts/protective eyewear?..... ☐ Yes ☐ No
20. Traveled outside the country in the past 9 months?..... ☐ Yes ☐ No

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: *Check "Yes" or "No" for each statement.*

Has the camper:

1. Ever been diagnosed or treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?... ☐ Yes ☐ No
2. Ever been diagnosed or treated for oppositional defiance disorder (ODD)?..... ☐ Yes ☐ No
3. Ever been diagnosed or treated for emotional or behavioral difficulties for an eating disorder?..... ☐ Yes ☐ No
4. During the past 12 months, seen a professional to address mental/emotional health concerns?..... ☐ Yes ☐ No
5. Had a significant life event that continues to affect the camper's life?..... ☐ Yes ☐ No

Please explain "Yes" answers in the space below, noting the number of the question. Camp Bernie may not be the right fit for some campers with special needs. If your child may require additional support, please contact the camp to set up a consultation to determine if YMCA Camp Bernie is able to provide that support.

Health-Care Providers:

Name of camper's primary doctor(s): _____ Phone: (____)_____

Name of camper's dentist: _____ Phone: (____)_____

Name of camper's orthodontist:____ _____ Phone: (____)_____

What Have We Forgotten to Ask? *Please provide in the space below any additional information about the camper's health that you think may be important or that may affect the camper's ability to fully participate in the camp program. Attach additional information if needed.*

Parents/Guardians Please Stop Here. Please keep a copy of this form for your records.

The below section must be completed by a licensed physician, and is required only for Overnight Campers:

I have reviewed the CAMPER HEALTH HISTORY FORM, and have discussed the camp program with the camper's parent(s)/ guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program.

Name of licensed provider (please print): _____

Title: _____ Date: _____ Phone (____)_____

Office Address _____

Signature or Stamp: