YMCA OF LONG ISLAND
SUMMER DAY CAMP
2021 MEDICAL FORM

GROUP #

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No child will be accepted without this medical form completed and signed by a physician. Form due to camp administrator before first day of child's camp session.

TO BE COMPLETED BY PARENT:

Child's Name: ______________________________

Home Address: ______________________________

City, State, Zip: ______________________________

Date of Birth: ____________ Age: ________ Sex: ________ Grade Completed: __________

Parent/Guardian 1: ______________ Phone: __________ Email: __________

Parent/Guardian 2: ______________ Phone: __________ Email: __________

Emergency Contacts:

Name: ______________ Relation: __________ Phone: __________

Name: ______________ Relation: __________ Phone: __________

Please list any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp (i.e., ADHD, eating disorder, significant life event, etc.)?

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Please list any medications both prescribed and over the counter. If medication needs to be administered while at camp, please fill out WRITTEN MEDICATION CONSENT FORM (located in Forms tabs in Parent Dashboard ymcali.org/camp):

____

Please list any allergies (medications, food, plants, etc.): ______________________________

____

Expected allergy reaction/treatment: ______________________________

____

Has your child had any serious injuries, illness, or hospitalizations we should know about?

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Does your child have Asthma? ______________________________

Does your child have Diabetes? ______________________________

Has your child ever experienced seizures? ______________________________

Medical Permission

I hereby authorize the administration of first aid during YMCA program hours by a trained staff member. In the event that I, or my family, cannot be contacted in an emergency, I hereby authorize EMS transportation to hospital and emergency room to provide treatment.

Parent Name (Print): ______________________________

PARENT SIGNATURE______________________________ **Date:** __________

TO BE COMPLETED BY PHYSICIAN: **Valid physical (within 1 year of start of camp). To be completed by physician and/or medical documentation to be attached.**

_______________________________ was examined on ____________ and found to be in satisfactory
(Child's Name) (Date)

health and free from communicable disease. There is no reason that this child should not participate in routine activities.

Physician Name: ____

Address: ____

City, State, Zip: ____

Tel: ____________________ Fax: ____________________

PHYSICIAN SIGNATURE:______________________________ **Date:** __________

HEALTH HISTORY:

Has this child had the chicken pox? ______________

If so, what date? __________

Date of TB Test: __________ Was TB test positive? __________

IMMUNIZATION HISTORY: LIST ALL DATES

VACCINE	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5	RECENT
DTaP or TdaP						
Tetanus Booster						
Mumps, Measles, Rubella (MMR)						
Polio (IPV)						
Haemophilus Influenzae Type B (HIB)						
Pneumococcal (PCV)						
Hepatitus B						
Hepatitus A						
Varicella (Chicken Pox) After January 1, 1999						
Meningococcal Meningitis (MCV4)						