



YMCA OF LONG ISLAND SUMMER DAY CAMP 2022 MEDICAL FORM

GROUP # _____

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.)?

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?

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)						
Hepatitis B						
Hepatitis A						
Varicella (Chicken Pox) After January 1, 1999						
Meningococcal Meningitis (MCV4)						