

Fanwood-Scotch Plains YMCA Personal Health and Medical Information

Camp Mak _____ Adventure Camp _____ Crossroads Camp _____ CIT _____

Name	Date of Birth
Street Address	Age
City State Zip	Sex ___ Female ___ Male

In Case of Emergency, Notify

Name	Relationship
Street Address	Home Phone
City, State, Zip	Other Phone

Immunizations

VACCINE TYPE	1 st Dose m/d/yr	2 nd Dose m/d/yr	3 rd Dose m/d/yr	4 th Dose m/d/yr	5 th Dose m/d/yr	Month/Day/Year
Diphtheria, Tetanus, Pertussis (DPT), (Td* or DT*)						
Polio-Oral Polio Vaccine (OPV) (if Salk Vaccine, indicate IPV)						
Measles, Mumps, Rubella (MMR)				XXXXXX	XXXXXX	XXXXXX
Measles				Or Serology	Date	Titer
Rubella				Or Serology	Date	Titer
Mumps				Or Serology	Date	Titer
Varicella				Or Serology	Date	Titer
Haemophilus B (Hib)						
Hepatitis B						
Other, Specify						

Name of physician _____ Phone number: _____

Signature of physician _____ Date of last physical _____

Description of any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp

Are you under any treatment or medication? Yes ___ No ___

Condition _____ Medication _____ Dosage _____

Do you have a condition, which would limit physical activity? Yes ___ No ___

Type of Limitation _____

Time length of limitation _____

Check any of the following that pertain:

___ Asthma ___ Convulsions ___ Diabetes ___ Fainting Spells ___ Heart Trouble

___ High Blood Pressure ___ Allergy / Allergic reaction (Specify) _____

___ Other (Specify) _____ Dietary Restrictions _____

Authorization/ Release

To the best of my knowledge, history is correct and complete. I know of no reason to restrict activity and can participate in all activities except as noted. In the event of an emergency, I hereby give permission to the physician selected by the director to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery.

Parent Signature _____

Date _____