Session:_____
Session Dates :_____

# YMCA Camp Menogyn
# HEALTH HISTORY FORM
# 2015

**Return to:**
YMCA Camp Menogyn
2125 E. Hennepin Ave
Suite 100
Minneapolis, MN 55413
Fax: 612 465 0559
By May 1st, 2015

This **Health History** form is required for all YMCA Camp Menogyn participants. **A new form must be completed each year of participation.** The information requested is intended to help us in the event of an emergency. This information will alert us to potential problems, special needs or accommodations that might be required. By Program Policy, all of the information is confidential and made available only to Administrative Staff, Medical Staff, and the Group Leader. **Please notify the YMCA Camp Menogyn Business Center should this information change prior to your arrival to camp.**

## Contact Information:

Participant Name: _____ Birth Date: _____ Gender: _____
Last First Middle

Home address _____
Street Address City State Zip

Emergency Contact: _____ Relationship to Camper _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

## The following must be completed for attendance:

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted. I authorize the camp and its staff to give reasonable first aid and administer over-the-counter medications as necessary.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as May be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form May be photocopied for trips out of camp.

I also give permission for my child to enter Canada with YMCA Camp Menogyn, if the trip involves such travel.

***Signature of Participant***: _____Date_____

## Waiver of Liability and Release of Indemnification:

I understand that although the Young Men's Christian Association of Minneapolis and Camp Menogyn have taken reasonable steps to provide my child with appropriate training, equipment and skilled staff for his/her outdoor experience, I acknowledge that some inherent risks cannot be eliminated without destroying the unique character of this activity. Such risks include, but are not limited to those associated with canoeing, portaging, backpacking, cooking over an open fire, encountering wild animals and other components of wilderness travel.

I also understand that me/my minor child will be transported to and from the activity by a properly licensed and qualified YMCA Camp Menogyn staff, volunteer, or contracted driver in a YMCA Camp Menogyn owned or leased vehicle.

Aware of these risks and willing to assume them, I hereby waive release and agree to hold harmless the YMCA, Camp Menogyn, and their representatives and successors for all claims or liabilities of any kind arising out of me/my minor child's participation in this camping experience. I have read the descriptions of the session, understand the requirements for participation, and give my child permission to participate. I assume and accept full responsibility for my/his/her participation.

I understand that the YMCA of Metropolitan Minneapolis and Camp Menogyn assume no responsibility for injuries or illnesses which me/my minor child May sustain as a result of my/his/her physical condition or resulting from participation in any camp activities or experiences. I expressly acknowledge on behalf of myself and my minor child and heirs that I assume the risk for any and all injuries and illness which May result from me/my minor child's participation in these activities. I hereby release and discharge the YMCA of Metropolitan Minneapolis and Camp Menogyn, its directors, officers, employees and volunteers from any and all claims for accidents, injuries, death, loss or damage which me/my minor child May suffer as a result of participating in these activities.

***Signature of Participant***_____ **Date:** _____

Camper Name_____ Session _____

## Insurance Information

Are you covered by family medical/hospital insurance? □ Yes □ No

If so, indicate carrier or plan name: _____ Group/Policy #: _____

☐ Photocopy of front and back of health insurance card must be attached to this form.

## Allergies

☐ No known allergies.

☐ I am allergic to: □ Food □ Medicine □ The environment (insect stings, iodine, etc.) □ Other

**(Please describe below what the camper is allergic to and the reaction seen.)**

_____

_____

_____

_____

## Medications

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire length of the trip. **Keep it in the original packaging/bottle** that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.

☐ I take NO medications on a routine basis.

☐ I takes medications as follows **(Please list below the medication, dosage, frequency and reason.)**:

_____

_____

_____

_____

Please list any non-prescription medications and ointments I **do not** want given to my child: _____

_____

_____

## Health History

| | | Yes | No | | | Yes | No |
|---|---|---|---|---|---|---|---|
| 1. | Ever been hospitalized? | ☐ | ☐ | 12. | Frequent ear infections | ☐ | ☐ |
| 2. | Ever had surgery | ☐ | ☐ | 13. | Had mononucleosis during the past 12 months? | ☐ | ☐ |
| 3. | Have recurrent/chronic illnesses? | ☐ | ☐ | 14. | Have problems with falling asleep/sleepwalking? | ☐ | ☐ |
| 4. | Had a recent injury? | ☐ | ☐ | 15. | Have a history of bedwetting? | ☐ | ☐ |
| 5. | Had asthma/wheezing/shortness of breath? | ☐ | ☐ | 16. | Ever had back/joint problems? | ☐ | ☐ |
| 6. | Have diabetes? | ☐ | ☐ | 17. | Have problems with diarrhea/constipation? | ☐ | ☐ |
| 7. | Had seizures/epilepsy? | ☐ | ☐ | 18. | Have any skin problems? | ☐ | ☐ |
| 8. | Had headaches? | ☐ | ☐ | 19. | Traveled outside the country in the past 9 months? | ☐ | ☐ |
| 9. | Wear glasses, contacts, or protective eyewear? | ☐ | ☐ | 20. | High blood pressure | ☐ | ☐ |
| 10. | Had fainting or dizziness? | ☐ | ☐ | 21. | Been a carrier of a communicable disease | ☐ | ☐ |
| 11. | Passed out/had chest pain during exercise | ☐ | ☐ | | (eg MRSA, VRE, Tuberculosis, etc) | | |

**Please explain any question you responded "Yes":** _____

_____

_____

_____

_____

Camper Name_____ Session _____

## Diet & Nutrition

☐ I have no dietary restrictions
☐ I have the following dietary restrictions. Include self-imposed restrictions, e.g. vegetarian. **(Please describe)**:

_____

_____

## Mental, Emotional & Social Health

| I have: | Yes | No |
|---|---|---|
| 1. Ever been treated for attention deficit disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)? | ☐ | ☐ |
| 2. Ever been treated for a psychiatric diagnosis such as depression, OCD, ODD, panic/anxiety disorder? | ☐ | ☐ |
| 3. Ever been treated for emotional or behavioral difficulties or an eating disorder? | ☐ | ☐ |
| 4. During the past 12 months, seen a professional to address mental/emotional health concerns? | ☐ | ☐ |
| 5. Had a significant life event that continues to affect the camper's life? (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others) | ☐ | ☐ |

**Please explain "Yes" answers:**

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_____

Is there anything else the Menogyn staff know about you that would be helpful in providing the best wilderness experience?

_____

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## What have we forgotten to ask?

Please provide in the space below any additional information about your health that you think important or that may affect your ability to fully participate in the camp program. **Attach additional information if needed.**

_____

_____

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_____

If for religious reasons, you cannot sign this form, please contact the camp for a legal waiver that must be signed for attendance.

Camper Name_____ Session _____

## Camp Menogyn Health Professional Notes

*For Camp use only*

**Pre-Trip Check In:** Date_____ Screened by_____

Temp_____ Throat_____ Feet_____

Allergies: _____

_____

Medications: _____

_____

Comments: _____

_____

_____

_____

**Post-Trip Check In:** Date_____ Screened by_____

Temp_____ Throat_____ Feet_____

Comments: _____

_____

_____

_____

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**Pre-Trip Check In:** Date_____ Screened by_____

Temp_____ Throat_____ Feet_____

Allergies: _____

_____

Medications: _____

_____

Comments: _____

_____

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_____

**Post-Trip Check In:** Date_____ Screened by_____

Temp_____ Throat_____ Feet_____

Comments: _____

_____

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