Camper Name: ______________________
Date of Birth: ______________________
Session Start Date: __________________

CAMP ICAGHOWAN

Health Exam Form

Parents: Have your Physician or Nurse Practitioner complete this form each year.

Camper's Legal Name: ______________________ Date of Birth: __________ Date of Medical Evaluation: __________

In my opinion, this person's condition ☐ **does** ☐ **does not** allow his/her participation in an active camp program.

Please describe any restrictions for participation: ______________________

Current treatment to be continued at camp (include current medications): ______________________

Explanation of any reported loss of consciousness, convulsion, or concussion: ______________________

This person is allergic to the following (food, medication, etc.): ______________________

Treatment for allergic response: ______________________

Any medically prescribed meal plan or dietary restrictions: ______________________

Any specific safety considerations (no top bunk, lifejacket required while swimming, weight restrictions camper can carry, necessary medications, etc): ______________________

Does this person have epilepsy? ☐ Yes ☐ No

Is this condition able to be controlled by camper? ☐ Yes ☐ No

Does this person have diabetes? ☐ Yes ☐ No

Is this condition able to be controlled by camper? ☐ Yes ☐ No

Does this person have asthma? ☐ Yes ☐ No

Is this condition able to be controlled by camper? ☐ Yes ☐ No

Immunization History: Provide the month and year for the tetanus immunization or send print-out from Physician's office.

Date of last Tetanus: ______________________ ☐ I Agree all other immunizations are up to date

Additional Parental or Doctor Notes: Include any other medical information that will assist us in making camp a positive experience. Attach additional paper if needed. ______________________

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Physician or Nurse Practitioner Signature: ______________________ Clinic Name: ______________________

Office Phone: __________ Clinic Address: ______________________

Date of Form Completion: ______________________

Please return this form:
YMCA Customer Service Center
2125 East Hennepin Avenue, Suite 100
Minneapolis, MN 55413
Phone: 612-822-2267 | Fax: 612-223-6322
Upload document at ymcamn.org/contact_us