Session:_____
Session Dates :_____

YMCA Camp Menogyn
HEALTH EXAM FORM
Summer 2012

Return to:
YMCA Camp Menogyn
2125 E. Hennepin Ave
Suite 100
Minneapolis, MN 55413
Fax: 612 223 6322
By May 1st, 2012

This **Health Exam** form is required for all YMCA Camp Menogyn participants and staff. **Please have your Physician or Nurse Practitioner complete this form each year** (the information can be based on an examination done with 24 months from the start of the camp session). 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, medical staff, and the group leader. **Please notify YMCA Camp Menogyn Business Center should this information change prior to your arrival to camp.**

Camper Name: _____Date Of Examination_____

In my opinion, this person's condition ☐ does ☐ does not allow his/her participation in an active camp program.
Please describe any restriction to 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, meds, etc):

Treatment for allergic response:

Any medically prescribed meal plan or dietary restrictions:

Any specific safety considerations (no top bunk, PFD required while swimming, weight camper can carry, etc):

Does this person have epilepsy? ☐ Yes ☐ No
Is condition able to be controlled by camper? ☐ Yes ☐ No
Does this person have diabetes? ☐ Yes ☐ No
Is condition able to be controlled by camper? ☐ Yes ☐ No
Does this person have asthma? ☐ Yes ☐ No
Is condition able to be controlled by camper ☐ Yes ☐ No
Has this person ever had or been a carrier of a communicable disease? ☐ Yes ☐ No
(e.g. MRSA, Tuberculosis, etc)

Immunization History: Provide the month and year for each immunization or attach a print out from Physician's office.
_____ Tetanus Booster _____ Hepatitis B
_____ Chicken Pox _____ MMR

Additional Parental or Doctor Notes: Include any other medical information that will assist us in making camp a positive experience. Use the back of this page, or attach extra pages if necessary.

MD/NP Signature:_____ **Clinic Name:** _____

Clinic Name:_____ **Clinic Address:**_____

Date of Form Completion:_____ **Office Phone:**_____