Session Start Date: _____

Health History 2019
YMCA Camp Widjiwagan

This Health History form is required for all Widjiwagan 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 and medical staff and the group leader.
Please notify the Camp Widjiwagan Administrative Office should this information change prior to your arrival at camp.

Please Return by **May 15** to YMCA Customer Service Center, 651 Nicollet Mall, Suite 500, Minneapolis, MN 55402, Fax: 612-223-6322
or upload document at **ymcamn.org/contact_us**

Camper Name: _____ Birth Date: _____ Age at camp: ____
Last First Middle

Insurance Information

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name _____ Group # _____

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

Immunizations

Date of your last tetanus shot? (required within 10 years):_____Date of your measles shot? _____

Are you up to date on remaining immunizations? ☐ Yes ☐ No

Allergies

☐ No known allergies.

This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, iodine, etc.) ☐ Other:
(Please describe below what the camper is allergic to and the reaction seen. For food allergies, please help us understand what the camper can and cannot eat so we can accommodate their needs.)

Diet & Nutrition

☐ This camper has no dietary restrictions

☐ This camper has the following dietary restrictions. (Please describe below, include specific information.)

Medications

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

☐ This person takes NO medications on a routine basis.

☐ This person takes medications as follows (Please indicate the Medication, Dosage, Frequency and Reason.):

The following must be completed for attendance

Camper Name:_____
Date of Birth:_____
Session Start Date:_____

Mental, Emotional & Social Health

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)? ☐ Yes ☐ No
2. Ever had mental, emotional or social difficulties (anxiety, behavioral, depression, etc.)? ☐ Yes ☐ No
3. Ever had an eating disorder (anorexia, bulimia)? ☐ Yes ☐ No
4. During the past 12 months, seen a professional to address mental/emotional/behavioral health concerns? ☐ Yes ☐ No
5. Had a significant life event that continues to affect the camper's life? ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

(Please explain "Yes" answers in the space below. Help us with any strategies or accommodations which are successful and will make this experience more rewarding for your camper.)

☐ Check box if you would like us to contact you regarding your child's Health History.

If so, please provide your phone number: _____

Health History

1. Ever been hospitalized? ☐ Yes ☐ No
2. Ever had surgery? ☐ Yes ☐ No
3. Have recurrent/chronic illnesses? ☐ Yes ☐ No
4. Had a recent infectious disease? ☐ Yes ☐ No
5. Had a recent injury? ☐ Yes ☐ No
6. Had asthma/wheezing/shortness of breath? ☐ Yes ☐ No
7. Have diabetes? ☐ Yes ☐ No
8. Had seizures? ☐ Yes ☐ No
9. Had headaches? ☐ Yes ☐ No
10. Had high blood pressure? ☐ Yes ☐ No
11. Wear glasses, contacts, or protective eyewear? ☐ Yes ☐ No
12. Had fainting or dizziness? ☐ Yes ☐ No
13. Passed out/had chest pain during exercise? ☐ Yes ☐ No
14. Had racing of your heart or skipped beats? ☐ Yes ☐ No
15. Had mononucleosis during the past 12 months? ☐ Yes ☐ No
16. Have problems with falling asleep/sleepwalking? ☐ Yes ☐ No
17. Have a history of bedwetting? ☐ Yes ☐ No
18. Ever had back/joint problems? ☐ Yes ☐ No
19. Have problems with diarrhea/constipation? ☐ Yes ☐ No
20. Have any skin problems? ☐ Yes ☐ No
21. Traveled outside the country in the past 9 months? ☐ Yes ☐ No
22. If applicable, at what age was your first menstrual period?, What was the longest time between your periods last year?

(Please explain "Yes" answers in the space below.)

What have we forgotten to ask?

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

Printed Name _____ Date _____

Signature of parent/guardian or adult camper/staffer _____