



YMCA
Camp Ockanickon
Camp Matollionequay
& Lake Stockwell

Camper Medical History & Medical Examination Form



YMCA
We build strong kids,
strong families, strong communities.

Complete and mail to: YMCA Camp Ockanickon, Inc. 1303 Stokes Road, Medford, NJ. 08055 Phone: 609-654-8225

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. The Camper Medical History (top half opposite side) must be completed by parents/guardians of minors. An update of Camper Medical History is required annually. The Medical Examination Form (bottom half opposite side) must be completed by a licensed medical physician for campers attending overnight camp. Revised 12/12/2008

<input type="checkbox"/> Ockanickon for Boys	<input type="checkbox"/> Matollionequay for Girls	<input type="checkbox"/> Lake Stockwell Day Camp
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10

CAMPER INFORMATION PLEASE PRINT CLEARLY - This is camper's permanent record.

Last Name	First Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB: / /	Age:
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FAMILY INFORMATION: Applies to those with whom the camper legally resides. Non-custodial parent information is requested below

Street Address	Father/Guardian 1 Last Name	Mother/Guardian 2 Last Name
City	First Name	First Name
State Province Zip	Home Phone	Home Phone
MEDICAL CONTACTS	Work Phone	Work Phone
	Cell Phone	Cell Phone
	Employer's Name	Employer's Name

EMERGENCY CONTACTS: (required) List two contacts other than parent(s)/custodian(s)

Phone Number:	Name	Name
Is the participant covered by family medical/hospital insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Camper	Relationship to Camper
If so, indicate carrier or plan name:	Home Phone	Home Phone
Group #	Work Phone	Work Phone
ID #	Cell Phone	Cell Phone

Important - The section below must be complete 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 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.

Signature of parent or guardian or adult camper/staffer: _____

Printed Name: _____ Date: _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer: _____ Date: _____

RESIDENT CAMPERS: DOCTORS MUST FILL OUT MEDICAL EXAM ON REVERSE SIDE AND IMMUNIZATION RECORD MUST BE ATTACHED

Camper Last Name:	First Name:	
CAMPER MEDICAL HISTORY - To be Completed by the Parent/Guardian.		
Please list all known food, medicine, or other allergies: (Describe reactions and management of the reactions)		
Please list any operations or serious injuries (dates):		
Please list any chronic or recurring illness, past medical treatment, psychological conditions, or Special Needs:		
(Girls) Has this camper Menstruated?	If no, has she been told about it?	If yes, is menstrual history normal?
Special considerations, suggestions, or reason(s) the camper or staff member should be exempted from camp activities:		
ALL MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER) MUST BE: <ul style="list-style-type: none"> • IN THEIR ORIGINAL LABELED CONTAINERS LISTING PATIENT AND DOSAGE. • TURNED IN TO THE NURSE AT CHECKIN BY THE PARENT/GUARDIAN. • SUFFICIENT IN QUANTITY TO LAST THE ENTIRE STAY AT CAMP. 		
RESIDENT CAMPERS ONLY: MEDICAL EXAMINATION - TO BE FILLED OUT BY LICENSED PHYSICIAN		
This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities. Laboratory tests done at discretion of physician.		
Height:	Weight:	BP:
		Resting Pulse:
		Date Last Tetanus Shot:
Immunizations up to date:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reason:
ATTACH A COPY OF HEALTH INSURANCE CARD (BOTH SIDES) AND IMMUNIZATION RECORD TO THIS DOCUMENT		
Recommendations and/or restrictions, physical or otherwise, while at camp. Any ongoing treatment or medications:		
In my opinion, the above applicant is able to participate in an active camp program.		
Doctor Name:	Date of Exam:	Date/Signed:
Address:	Phone:	
Doctor's Signature:		