# 2020 SUMMER DAY CAMP

## Day Camp Summer Medical Registration

**Child's Name:** _____

CAMP(S) ATTENDING: ❑ Kamp Kermit ❑ KIDS Camp

### Medication

Will your child require any medication while at day camp? Yes ☐ No ☐

If yes, please list medication: _____ (You will be required to complete a "Medication Authorization Form")

### Health History

Check any special medical condition(s) that your child may have (you must check at least one box in this section).

- ☐ No Medical Condition
- ☐ Sensitivity to the sun
- ☐ Asthma
- ☐ Epilepsy/Seizure Disorder
- ☐ Heart Problems
- ☐ Diabetes
- ☐ Any disorder including Cognitively Disabled, LD, ADD, ADHD or Autism (please circle which disorder)
- ☐ Cerebral Palsy/Motor Disorder
- ☐ Non-Food Allergies, please specify _____
- ☐ Food Allergies, specify food(s) _____
- ☐ Milk Allergy (attach a statement from the Doctor indicating the acceptable alternative)
- ☐ Gastrointestinal or feeding concerns including special diet
- ☐ Other Condition(s) requiring special care, please specify _____

1. Please describe any health conditions checked above: _____
2. Triggers that may cause problems (specify): _____
3. Signs or symptoms to watch for (specify): _____
4. Action steps for camp staff to take (specify): _____
5. When to call parents regarding symptoms or failure to respond to treatment: _____
6. When to consider emergency care: _____
7. Any additional information that may be helpful to staff: _____

*Please contact your Camp Director if your child has any special medical needs or conditions that camp should be aware of.

## PARENT CONSENT/AUTHORIZATION

Please initial each line indicating that you understand each item.

_____ I am aware that a copy of the YMCA Licensing Rules for camp are available at the program for review at any time.

_____ I authorize the YMCA to take my child on all field trips; whether by bus transportation, walking, or biking; during any of the YMCA Summer Camp program days my child is enrolled.

_____ I ❑ **give** or ❑ **do not** give permission for promotional photographs or video to be taken of my child.

_____ In the event of an emergency, I authorize any medical treatment that may be needed. I understand that in the event of an injury, I will be contacted first and this waiver will only be necessary if I or my emergency person cannot be reached.

_____ I authorize camp staff to apply bug repellent and/or sunscreen to my child at camp.

_____ I understand that all information provided is confidential, and is only used as a resource in understanding my child.

_____ I understand a two-week written notice is required to cancel my child's week of camp and receive any refund.

_____ I understand that I will receive my camp payment minus a $25 cancellation fee if written notice is provided to the camp office as stated.

_____ I authorize camp staff to provide routine health care, administer prescribed medication or seek emergency treatment if necessary.

_____ I understand that emergency medical transport and medical treatment are the financial responsibility of the parent and that Camp and the Greater Green Bay YMCA are not financially responsible for those costs.

**PARENT/GUARDIAN SIGNATURE:** _____ **DATE:** _____

**THIS HEALTH FORM MUST BE SUBMITTED AT LEAST TWO (2) WEEKS PRIOR TO YOUR CHILD'S SESSION TO THE ADDRESS LISTED AT THE BOTTOM OF THIS FORM.**

# IMMUNIZATION HISTORY (Complete the immunization history & physician/medical facility information below)

**First Child's Name:** _____

**Birth Date:** _____

**School:** _____

**Second Child's Name:** _____

**Birth Date:** _____

**School:** _____

**Minimum requirements include <**

| 2 years through 4 years | 4 DTP/DTaP/DT | 3 Polio | 1 MMR | 3 HepB | 3 Hib | 3 PCV | 1 Varicella |
|---|---|---|---|---|---|---|---|
| At Kindergarten entrance | 4 DTP/DTaP/DT/Td | 4 Polio | 2 MMR | 3 HepB | | | 2 Varicella |

## Immunization History:

| TYPE OF VACCINE | First Dose mo/day/yr | Second Dose mo/day/yr | Third Dose mo/day/yr | Fourth Dose mo/day/yr | Fifth Dose mo/day/yr |
|---|---|---|---|---|---|
| DTP/DT/Td DIPHTHERIA-TETA-NUSPERTUSSIS (Whooping Cough) | | | | | |
| POLIO | | | | | |
| HAEMOPHILUS INFLUENZA b (HIB) | | | | | |
| PNEUMOCOCCAL CONJUGATE (PCV) | | | | | |
| HEPATITIS B | | | | | |
| MEASLES, MUMPS, RUBELLA (MMR) | | | | | |
| VARICELLA (Chicken Pox) | | | | | |

☐ For religious reasons, this child should not be immunized.

☐ For personal conviction reasons, this child should not be immunized.

### Child's Physician/Medical Facility:

Physicians Name: _____

Address: _____

Phone #: _____

## Immunization History:

| TYPE OF VACCINE | First Dose mo/day/yr | Second Dose mo/day/yr | Third Dose mo/day/yr | Fourth Dose mo/day/yr | Fifth Dose mo/day/yr |
|---|---|---|---|---|---|
| DTP/DT/Td DIPHTHERIA-TETA-NUSPERTUSSIS (Whooping Cough) | | | | | |
| POLIO | | | | | |
| HAEMOPHILUS INFLUENZA b (HIB) | | | | | |
| PNEUMOCOCCAL CONJUGATE (PCV) | | | | | |
| HEPATITIS B | | | | | |
| MEASLES, MUMPS, RUBELLA (MMR) | | | | | |
| VARICELLA (Chicken Pox) | | | | | |

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