# Hampshire Regional YMCA
## Camper Confidential Information Form

To be used for all Hampshire Regional YMCA Camps
Please complete one per camper.

Please follow instructions below:
1) **Complete** all applicable fields of this form.
2) **Submit completed form** along with **immunization records, current physical** (within last 15 months), and **registration form** at time of registration.
   **Physical MUST BE signed by primary health care provider.*

***Using the grid to the right, indicate the camp and session(s) this camper will be attending by shading in the corresponding boxes.***

| | Norwich | Gymnastics | Koala |
|---|---|---|---|
| 6/26-6/30 | *x* | *S1* | *S1* |
| 7/03-7/07 | *S1* | *S2* | *S2* |
| 7/10-7/14 | | *S3* | *S3* |
| 7/17-7/21 | *S2* | *S4* | *S4* |
| 7/24-7/28 | | *S5* | *S5* |
| 7/31-8/4 | *S3* | *S6* | *S6* |
| 8/07-8/11 | | *S7* | *S7* |
| 8/14-8/18 | *S4* | *S8* | *S8* |
| 8/21-8/25 | | *x* | *S9* |
| 8/28-9/1 | *S5A* | *x* | *x* |

Camper Name:_____ Birthdate: ___/___/_____ Age at Camp:_____
Last First MI Mon. Day Year

Camper Mailing Address:_____
Street City State Zip

Camper's Biological Sex: ☐M ☐F ☐Intersex Camper Identifies As: ☐M ☐F ☐Other_____

**Primary Parent/Care Taker** Resides with Camper? ☐Yes ☐No

Name:_____ Relationship:_____ Best Phone: ( ____ )____-_____

E-Mail:_____ Alt. Phone: ( ____ )____-_____

Home Address _____
(If different than camper's) Street City State Zip

**Secondary Parent/Care Taker** Resides with Camper? ☐Yes ☐No

Name:_____ Relationship:_____ Best Phone: ( ____ )____-_____

E-Mail:_____ Alt. Phone: ( ____ )____-_____

Home Address _____
(If different than camper's) Street City State Zip

**Additional Emergency Contacts to be contacted in case of emergency**

Name:_____ Relationship:_____ Best Phone: ( ____ )____-_____

Name:_____ Relationship:_____ Best Phone: ( ____ )____-_____

**Camper's Health Care Providers**

Primary Health Care Provider's Name:_____ Phone: ( ____ )____-_____

Primary Health Care Provider Address:_____

Other Health Care Provider:_____ Type of Care _____ Phone: ( ____ )____-_____

**Medical Insurance Information:** This camper is covered by healthcare insurance. ☐Yes ☐ No

Insurance Co._____ Insurance Co. Phone: ( ____ )____-_____ Policy # _____

Subscriber's Name: _____ Relationship to Camper:_____

**Immunization History**

☐This camper has been fully immunized and the current immunization record is attached to this health form.
☐This camper has not been fully immunized for the following reason:
☐ Religious or family preference ☐ Immunization poses health risk to camper

***If camper has not been fully immunized, please sign the following statement:*** I understand and accept the risks to my child from not being fully immunized and that my child may be excluded from camp if there is an incidence of a communicable disease, per MA Department of Public Health and Safety regulations.

Parent/Guardian Signature_____ Date:___/___/_____

**Non-Prescription Medications** – Some non-prescription medications **may** be stocked at **Camp Norwich** and are used on an as needed basis to manage illness or injury. A call home or to the camper's PHCP is placed before delivering any medication. ***Please cross out medications that this camper SHOULD NOT be given.***

| | | | |
|---|---|---|---|
| Ibuprofen (Motrin) | Antacid | Aloe for burns | Diphenhydramine antihistamine (Benadryl) |
| Acetaminophen (Tylenol) | Calamine Lotion | Generic Cough Drops | Antibiotic Cream or Ointment |

**Camper Name**_____
Last First MI

**Camps:** Koala ☐ Gym ☐ Norwich ☐

**Sessions Attending** Koala _____ Gym _____ Nor _____

**Additional Information**

Camper's Preferred Name: _____

Parents' Marital Status

☐Married ☐Separated ☐Divorced (# of years_____) ☐Deceased ☐Not married, but together ☐Other _____

List adult(s) camper lives with:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

How many child(ren) does camper live with? _____

Has camper participated previously in programs in which s/he is separated from family? ☐Yes ☐No

If yes, how long away from home?_____

Is this camper fully toilet-trained? ☐Yes ☐No Does camper need bathroom reminders? ☐Yes ☐No

Is this camper in the appropriate grade for his/her age: ☐Yes ☐No

If no, please select: ☐Above normal grade level ☐Below normal grade level

**If gymnastics camp**: How many years of experience in the sport? _____

**If Camp Norwich 3-9th grade:** Does this camper require a night time diapers? ☐Yes ☐No

Does this camper tend to have nightmares or other sleeping issues? ☐Yes ☐No

Please let us know about any accommodations we can make, special fears or anxieties this camper may have pertaining to camp, unique behavioral challenges not yet addressed on this form, or any other information we should understand in order to provide this camper with the best possible camp experience.

_____

_____

_____

_____

_____

_____

Do you wish to be contacted by the camp director prior to the start of camp? ☐Yes ☐No

Preferred method of contact: ☐Phone_____ ☐E-mail_____

**Parent/Guardian Authorization for Health Care:**

**I understand** that the information on this form will be reviewed by the camp director and/or the camp nurse. At his/her discretion, the information will be shared with camp staff to help ensure the best possible camp experience for this camper. All information provided will be reviewed, but camper information will be shared only when necessary and only to those who need to know in order to enhance the experience.

**I have answered ALL questions** as completely as possible keeping in mind that this information makes a significant difference in the quality of experience the Hampshire Regional YMCA Day Camps are able to provide.

**I attest that** the information on this form is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining Licensed Health Care Provider. I give permission to the Licensed Health Care Provider selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine healthcare and in emergency situations. If I cannot be reached in an emergency, I give permission to the Licensed Health Care Provider to hospitalize, transport, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photo copy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's health care professional and/or health care supervisor about my child's health status.

Parent/Guardian Signature: _____ Date:____/____/_____

Parent/Guardian Printed Name:_____ Relationship to Camper:_____

***If for religious or other reasons you cannot sign this, contact the HRYMCA for a legal waiver that must be signed for attendance.***

**Camper Name**_____ **Birthdate:** ____/____/_____ **Age at Camp** :_____
Last First MI

**Allergies:** ☐ No known allergies OR Allergic to: ☐ Food ☐ Medicine ☐ Environmental Factors ☐ Other

Please describe the nature and severity of this camper's allergies:

**Epi-Pens:** Will you be providing epi-pens while camper is attending? ☐Yes ☐No If yes, how many will you be providing? ☐ One ☐ Two

**Allergy Medication:** Will you be providing allergy medication while camper is attending? ☐Yes ☐No

**Diet, Nutrition:** ☐ No special dietary needs ☐Vegetarian ☐Vegan ☐Lactose Intolerant ☐Gluten Intolerant ☐Other

Please describe the nature of this camper's dietary or nutritional needs:

**Physical Restrictions:** ☐ Camper can participate without restrictions ☐ Camper can participate with restrictions/adaptions

Please describe requested restrictions or adaptations:

**Mental/Emotional/Social:**

1. Camper has been treated for emotional or behavioral difficulties.....☐Yes ☐ No
2. Camper has seen a professional to address mental or emotional health concerns during the last 12 months.....☐Yes ☐ No
3. Camper has had a significant life event that continues to affect his/her life (abuse, death of loved one, family change, disaster, etc.).....☐Yes ☐ No

Please explain any "Yes" answers in the space below and describe restrictions or adaptations requested, if any:

**General Health History –** Check "Yes" or "No" for each statement below. Explain "Yes" answers in the space below.

Has/does the camper:

| | | | |
|---|---|---|---|
| 1. Been hospitalized in last 12 months? | ☐Yes ☐No | 13. Ever had surgery? | ☐Yes ☐No |
| 2. Have Asthma? (Explain inhaler or other treatment) | ☐Yes ☐No | 14. Have scoliosis? | ☐Yes ☐No |
| 3. Have Allergies? | ☐Yes ☐No | 15. Have orthopedic issues? (Explain recent injuries) | ☐Yes ☐No |
| 4. Have diabetes? (Explain type and treatment) | ☐Yes ☐No | 16. Have a neurological disorder?(Explain condition) | ☐Yes ☐No |
| 5. Have bleeding problems? | ☐Yes ☐No | 17. Wear glasses, contacts, or protective eyewear? | ☐Yes ☐No |
| 6. Have cancer? | ☐Yes ☐No | 18. Have orthodontics (braces)? | ☐Yes ☐No |
| 7. Had mononucleosis in the past 12 months? | ☐Yes ☐No | 19. FEMALES: Have problems with menstruation? | ☐Yes ☐No |
| 8. Have trouble with migraines? | ☐Yes ☐No | 20. Ever had back or joint problems? | ☐Yes ☐No |
| 9. Had concussions or head injuries? (Provide dates) | ☐Yes ☐No | 21. Have gastrointestinal problems? (Explain condition) | ☐Yes ☐No |
| 10. Have any skin problems? | ☐Yes ☐No | 22. Have hearing impairment? (Left Side, Right Side?) | ☐Yes ☐No |
| 11. Have Cystic Fibrosis? | ☐Yes ☐No | 23. Have vision impairment? (Glasses, Contacts?) | ☐Yes ☐No |
| 12. Have a heart condition? | ☐Yes ☐No | 24. Have a chronic/recurring condition? | ☐Yes ☐No |

Please explain any "Yes" answers in the space below. Please note the number question to which you are referring.

**Camper Name**_____ **Birthdate**: ____/____/_____ **Age at Camp** :_____
First M Last

**Medications to be administered at camp (PLEASE CHECK BOX BELOW):**

☐ This camper ***will not*** need medications administered at camp. ☐ This camper ***will*** need medications administered at camp.

**IF CAMPER **WILL NEED MEDICATIONS** ADMINISTERED AT CAMP, PLEASE READ THE INSTRUCTIONS BELOW ENTIRELY AND FILL OUT ALL FIELDS FOR THE ADMINISTERATION OF ROUTINE MEDICATIONS AT CAMP.*

Instructions for sending medications to camp are as follows. Please follow all instructions or the YMCA staff will not administer medication to camper.

- All medication must be delivered to camp in **its original container, bearing the pharmacy label (if prescribed)**, which includes the camper's name, prescriber's name, date filled, name of medication, directions for use, warnings, and other standard information.
- The medication container delivered to camp **should contain exactly as many doses of the medication as will be administered** during the session(s) at camp - no more and no fewer.
- All over-the-counter medication must be delivered to camp in its original container, including its original label and directions for use.
- **Medications must be given to a camp staff directly** (not brought to camp by the camper).
- All medications delivered to camp shall remain in the YMCA's possession for the entire course of the medication or until the camper's last day at camp, at which time the medication will be given back to the parent/guardian directly.
- **If the medication cannot be returned directly to the parent on the camper's last day, it will be destroyed at the end of the session**.
- All medications shall only be administered by a licensed health care professional or the camp's health supervisor under the oversight of a consulting physician.

**MEDICATION #1**

Name of Medication:_____ Time(s) to be administered:_____ ☐As Needed

Name of Licensed Prescriber_____ Date Started___/____/_____ Duration of Order:_____

Dose given at camp:_____ Route of administration_____Storage:_____

Quantity provided:_____ Specific Directions (i.e. with food, with water): _____

Specific Precautions:_____

Possible Side Effects:_____

**MEDICATION #2**

Name of Medication:_____ Time(s) to be administered:_____ ☐As Needed

Name of Licensed Prescriber_____ Date Started___/____/_____ Duration of Order:_____

Dose given at camp:_____ Route of administration_____Storage:_____

Quantity provided:_____ Specific Directions (i.e. with food, with water): _____

Specific Precautions:_____

Possible Side Effects:_____

***For additional medications, please download the medical administration form from our website, www.hrymca.org***

**Authorization to Administer Medication from Parent**

I hereby agree to all instructions listed above and verify that I have filled out all required information accurately and to the best of my ability. Additionally, I hereby authorize the Hampshire Regional YMCA's health supervisor to administer the above medications to my child, _____.

(Name of Camper)

Parent/Guardian Signature: _____ Date:____/____/_____