AYC
EST. 1898
Athens Y Camps

HEALTH EXAMINATION FORM

_____ Year

Please check the appropriate boxes: ☐ Athens Y Camp ☐ Camp Chattooga ☐ Staff ☐ Camper

SECTION A: TO BE COMPLETED BY PARENT/GUARDIAN AND SIGNED

Name _____

Birthdate _____ Age _____

Parent or Guardian _____ Cell Phone _____

Home Address _____ Home Phone _____

City _____ State _____ Zip _____ Work Phone _____

Second Parent or Guardian or Emergency Contact _____

Cell Phone _____ Home Phone _____ Work Phone _____

If not available in an emergency, notify _____

Cell Phone _____ Home Phone _____ Work Phone _____

NO CHILD WILL BE ACCEPTED AS A CAMPER WITHOUT HEALTH INSURANCE OR OFFICIAL PROOF OF MEDICAID

(Please attach a copy of your health insurace card)

FRONT

BACK

PARENT/CAMPER AGREEMENT:

The health history is correct so far as I know, and the child named above has permission to engage in all prescribed camp activities, except as noted. The staff of the Athens Y Camps exercise caution in the conduct of all camp activities; however, they do not assume responsibility for accidents, injury or illness suffered by its campers.

I, as parent or guardian of the child named above, individually and on behalf of the camper, hereby release, discharge and agree to indemnify the Athens Y Camps, their directors and employees from all liability for damage, injury or illness to the camper or their property relating to or deriving from their stay at the Athens Y Camps or participation in or travel to or from the Athens Y Camps activities.

I, as parent or guardian of the child named above, hereby grant permission for the Athens Y Camps to use any photographs of the camper taken during the camping session in any media for promotional purposes.

AUTHORIZATION FOR TREATMENT:

I, as parent or guardian of the child named above, hereby give permission to the medical or dental personnel selected by the camp to order x-rays, routine test, treatment and transportation for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, order injections, anesthesia or surgery, including hospitalization for the child named above. The completed forms may be photocopied for trips out of camp. I further acknowledge that the Athens Y Camps do not carry health or accident insurance for campers and that I will be responsible for payment of all charges related to the medical or dental services provided.

_____ _____

***SIGNATURE OF PARENT/GUARDIAN** Date

Any other known allergies: _____

Allergies drugs: _____

Recent Exposure to contagious disease: _____

If yes, name and disease: _____

List serious or chronc illnesses that the child has ever had and operations or serious injuries:

_____

over

DUE ONE MONTH BEFORE CAMP ARRIVAL

Name of Camper _____

HEALTH HISTORY: Does your child have any of the following? For all yes answers please mark "x" in the box and explain in the space provided below. Include your usual method of treatment and have your child bring to camp the medication required.

- ☐ high blood pressure
- ☐ reactions to stings/bites/poisonous plants
- ☐ other
- ☐ sleep walking
- ☐ bedwetting
- ☐ skin rashes/problems
- ☐ frequent sore throats
- ☐ bronchitis
- ☐ asthma
- ☐ diabetes
- ☐ seizures
- ☐ fainting spells
- ☐ ADHD
- ☐ ADD
- ☐ stomach upsets
- ☐ bedwetting
- ☐ skin rashes/problems

_____

_____

List medications taken daily/dosages: _____

List medications taken as needed/dosages: _____

Describe any other health conditions requiring treatment or restrictions: _____

_____

_____

SECTION B: TO BE COMPLETED BY PHYSICIAN SIGNED

Every child is required to have a medical examination performed by a physician within 12 months prior to camp attendance. This section must be completed and signed by a physician at that time.

Date of examination: _____

General condition or Appraisal: _____

Height: _____ Weight: _____ Blood Pressure: _____

Allergies: _____

List any current or on-going treatment and/or medications: _____

_____ I believe this child is able to attend camp and participate in all camp activities

_____ I believe this child is able to attend camp and participate in camp activities with the following restrictions and recommendations:

_____

_____

_____

Examining Physician Name: _____ Signature: _____

Address: _____

Phone _____ Date: _____

IMMUNIZATION RECORD (to be completed by parent or physician)

Please send a copy fo the immunization record or complete below, listing the last date the vaccine was given:

DTP/DPTA _____ Tetanus _____

Polio _____ MMR _____

Hepatitis B _____ Whooping Cough _____

- ☐ Measles
- ☐ Chicken Pox
- ☐ German measles
- ☐ Mumps
- ☐ Hepatitis