FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Medical History

YMCA Camp Ockanickon, Inc. 1303 Stokes Road, Medford, NJ 08055 Phone 609-654-8225

☐ Administration	☐ Food Service	☐ Lake Stockwell Day Camp	☐ Matollionequay for Girls
☐ Maintenance	☐ Outdoor Center	☐ Ockanickon for Boys	☐ School's Out at Camp

CAMPER INFORMATION				
Last Name	First Name	☐ Male ☐ Female	DOB	Age
Address				

MEDICAL INFORMATION	**EMERGENCY CONTACT INFORMATION**	**EMERGENCY CONTACT INFORMATION**
Physician	Name	Name
Phone	Relationship	Relationship
Dentist	Home Phone	Home Phone
Carrier / Plan Name	Cell Phone	Cell Phone
Group #	Work Phone	Work Phone
ID #	Email	Email

IMPORTANT- The section below must be completed for camp attendance

This health history is accurate and complete to the best of my knowledge. My child 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 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 of camper OR adult camper/staff member___________________________________

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SECTION 1: MEDICAL HISTORY- To be Completed by the PARENT/GUARDIAN OF CAMPER or ADULT STAFF MEMBER
Please list all known food, medicine, or other allergies. (Describe reactions and management of the reactions.)
Please list any operations or serious injuries with dates.
Please list any chronic or recurring illness, past medical treatment, psychological conditions or Special Needs.
Special considerations, suggestions, or reasons the camper should be exempt from camp activities?
Date of Last Tetanus Shot
ALL MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER) MUST BE: • IN THEIR ORIGINAL LABELED CONTAINERS LISTING PATIENT AND DOSAGE • TURNED IN TO THE HEALTH PROFESSIONAL AT CHECKIN BY THE PARENT/GUARDIAN OR ADULT STAFF MEMBER • SUFFICIENT IN QUANTITY TO LAST THE ENTIRE STAY AT CAMP