YMCA Camp Arroyo
Health History, Authorization & Release Form

(Complete one form per child)

Responsible Organization (Your School's Name): _____

Student's Last Name:

CHILD'S NAME _____ ☐ M ☐ F Birth Date _____
Last *First*

Home address _____ City_____ Zip_____

Child's school teacher _____

CUSTODIAL PARENT/GUARDIAN NAME(S) _____

Home address _____ City_____ Zip_____ (*If different from above)*

Home phone_____ Work phone _____ Pager/Cell Phone _____

E-mail_____

SECOND PARENT/GUARDIAN OR EMERGENCY CONTACT NAME_____

Home address _____ City_____ Zip_____

Home phone_____ Work phone _____ Pager/Cell Phone _____

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, please indicate carrier or plan name_____ Policy # _____ Phone #_____

OPTIONAL: ***The YMCA is committed to serving all of its community. Your response here is optional, but your response will help us determine how well we are achieving this goal.***

Please indicate your race/ethnicity: ___Black/African-American ___Hispanic/Latino ___Caucasian/White

___Asian/Pacific Islander ___American Indian/Alaskan Native ___Multi-racial ___Other

*****IMPORTANT – THE SECTION BELOW MUST BE COMPLETED FOR ATTENDANCE*****

Parent / Guardian Authorization

This health history is correct, so far as I know, and the person herein has permission to engage in all prescribed program activities. I give permission to the physician selected by the above-named Responsible Organization or the YMCA of the East Bay to order X-Rays, routine tests, and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the above-named Responsible Organization or the YMCA of the East Bay to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child named above. Recognizing that the above-named Responsible Organization or the YMCA of the East Bay will do their best to ensure a safe experience, I understand that certain dangers or accidents may occur. I hereby release the above-named Responsible Organization and the YMCA of the East Bay, The Taylor Family Foundation, East Bay Regional Park District, their officers, directors, employees, agents and representatives, from all responsibility and liability of any nature, including claims from injury, illness, death, loss or damage, resulting from my child's participation in program activities. I voluntarily give the YMCA of the East Bay and its legal representatives and assigns, permission, without limitation or obligation, to use and publish quotes and photographs of me and my family members to promote YMCA programs. I understand that these quotes and photographs may be used in brochures, billboards, advertisements, marketing collateral, and on the association's Website. I release the YMCA of the East Bay and its legal representatives and assigns from all claims and liability relating to these quotes and photographs. This form may be photocopied for use away from the main program site. I authorize the above-named Responsible Organization and its staff and the YMCA of the East Bay staff to administer First Aid, CPR and to apply sunscreen to my child's exposed skin, on an as-needed basis.

Parent/Guardian Signature: _____ **Date:** _____

Name (printed): _____ **Relationship to Participant:** _____

ALLERGIES

List all known allergies to medication, food, insect bites, hayfever, plants, animals, sunscreen, etc. Also please describe the reaction, and management of reaction. _____

_____

EPI-PEN: Does your child have an Epi-Pen for allergic reactions? ☐Yes ☐ No If Yes, does he/she know how to use it? ☐Yes ☐ No

Is your child authorized to carry and use the Epi-Pen? ☐Yes ☐ No

ASTHMA: Does your child have asthma? ☐ Yes ☐ No If so, does he/she carry an inhaler? ☐ Yes ☐ No

Does he/she have a nebulizer? ☐ Yes ☐ No Does he/she know how to use his/her inhaler/nebulizer? ☐ Yes ☐ No

If your child has an Epi-Pen, inhaler and/or nebulizer, please send it with them to Camp Arroyo and list it in the MEDICATIONS section below

GENERAL HEALTH QUESTIONS

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐	8. Ever had chest pain during or after exercise?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐	9. Ever been diagnosed with a heart condition?	☐	☐
3. Have frequent headaches?	☐	☐	10. Have frequent nose bleeds?	☐	☐
4. Ever passed out during or after exercise?	☐	☐	11. Have diabetes?	☐	☐
5. Ever been dizzy during or after exercise?	☐	☐	12. Have problems with sleepwalking?	☐	☐
6. Ever had seizures?	☐	☐	13. Tetanus shot within the last 10 years?	☐	☐
7. Have a history of bedwetting?	☐	☐	14. Other? _____		

Please explain any "yes" answers, noting the number of the questions. _____

_____

RESTRICTIONS AND OTHER CONCERNS

Food Restrictions The participant does not eat: ☐ Dairy Products ☐ Red Meat ☐ Pork ☐ Poultry ☐ Eggs ☐ Gluten (wheat) ☐ Nuts ☐ Other (describe) _____

Physical Restrictions Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

_____

_____

Other Concerns about the participant's behavior, emotional or mental health about which the camp should be aware:

_____

_____

MEDICATIONS

- Pack all prescription medications & any over-the-counter drugs that you think your child may need.
- Please list ALL medications (including over-the-counter or prescription drugs) taken routinely.
- Bring enough of the medication to last the entire time at camp.
- Keep the medication in the **original packaging/bottle** that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

*****Prescription and over-the-counter medication without the original packaging and instructions can not be distributed. *****

☐ This person takes **NO medications** on a routine basis. OR ☐ This person **takes medications** as follows:
(Include prescription AND nonprescription drugs such as Tylenol, Benadryl, etc.)

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #4 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Precautions, special instructions, possible adverse effects, or comments: