YMCA CAMP SANTA MARIA

YMCA OF NORTHERN COLORADO

Supplemental Health History
Only needed for Camp Santa Maria

PARENT/GUARDIAN: Complete top section and give this form and a copy of your completed Supplemental Health History form to your child's health-care provider for review.

Camper Name:_____ Gender _____Age On Arrival At Camp: _____DOB:_____

Parent/Guardian:_____DOB:_____

Home Phone: _____Cell Phone: _____ Work Phone:_____

HEALTH CARE PROVIDER: Please review the Supplemental Health History form (page 3) and complete all remaining sections of this form (page 4). Attach additional information if needed. If physical exam is not completed during office visit please provide a signed copy of the most recent physical completed with in the last 12 months.

PHYSICAL EXAM (ACA accreditation standards specify physical exam completed within last 12 months.)

Physical exam completed today: ☐ YES / ☐ NO If 'No', date of last physical (mm/dd/yr.): _____

Weight (lbs): _____ Height (ft, in): _____Blood Pressure _____

ALLERGIES/ASTHMA: ☐ None Known / ☐ Yes Allergy (list foods, medications, environment, other):_____

_____

Symptoms which occur:_____

Recommended Treatment:_____

Asthma Health Care Plan (list trigggers, medications, inhaler use):_____

_____

MEDICATIONS: ☐ No daily medications / ☐ Yes, will take the following medication(s) while at camp (name, dose, frequency-describe below)

_____

_____

NON-PRESCRIPTION MEDICATIONS: The following medications are commonly stocked in the camp Health Center and are used on an **as needed basis** to manage illness or injury. Select or cross out those items the camper **should not** be given.

☐ Acetaminophen (Tylenol) ☐ Ibuprofen (Advil, Motrin) ☐ Phenylephrine (Sudafed PE) ☐ Pseudoephedrine (Sudafed) ☐ Chlorpheneramine maleate
☐ Guaifenesin ☐ Dextromethorphan ☐ Diphenhydramine (Benadryl) ☐ Generic cough drops ☐ Chloraseptic (Sore throat spray)
☐ Lice shampoo or scabies cream (Nix or Elimite) ☐ Calamine lotion ☐ Bismuth subsalicylate (Pepto-Bismol) ☐ Laxatives for constipation (Ex-Lax)
☐ Hydrocortisone 1% cream ☐ Topical antibiotic cream ☐ Aloe

MEDICAL TREATMENTS: ☐ None / ☐ Yes, the camper is undergoing treatment at this time for the following condition (describe below)

_____

_____

Other treatments/therapies to be continued at camp: ☐ None _____

_____

RESTRICTIONS: ☐ No restrictions / ☐ Yes, the camper will require limitations or restrictions to the following activities while at camp (describe below)

_____

_____

I have reviewed the Supplemental Health History forms and have discussed the camp program with the camper's parent(s)/guardian(s). It is in my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

NAME OF LICENSED PROVIDER Print Name: _____ Signature: _____ Date: _____

Office Address**:**_____

Phone :_____