

FOR STONY BROOK ACRES
PLEASE RETURN TO:

Scantic Valley Y Family Center
45 Post Office Park, Wilbraham, MA 01095-1227

FOR CAMP WEBER/FUN CITY/FUN CITY EAST/
TEEN CAMP/SMALL FRY EXPLORER
PLEASE RETURN TO:

YMCA of Greater Springfield
275 Chestnut Street, STE 1, Springfield, MA 01104

This side to be filled out by the parent/guardian and checked with physician at time of examination.

Name: _____ Birthdate: _____ Sex: M F Age _____
Last First Middle Initial Please Circle

Parent/Guardian: _____ Home phone: _____

Home Address: _____
Street and number City State Zip Code

Business Address: _____ Business Phone: _____

Second Parent/Guardian: _____ Home phone: _____

Home Address: _____
Street and number City State Zip Code

Business Address: _____ Business Phone: _____

If Parent/Guardian is not available in an emergency, please notify:

Name: _____ Home Phone: _____ Other Phone: _____
Name: _____ Home Phone: _____ Other Phone: _____

Health History: (Check and give approximate dates)

_____ Frequent Ear Infections
_____ Heart Defect/Disease
_____ Convulsions
_____ Diabetes
_____ Bleeding/Clotting Disorder
_____ Hypertension
_____ Mononucleosis

Diseases:
_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps

Allergies:
_____ Hay Fever
_____ Ivy Poisoning, etc.
_____ Insect Stings/Bites
_____ Penicillin
_____ Other Drugs
_____ Asthma
_____ Other (please specify)

Do you carry family medical/hospital insurance? Yes No
Please circle one

If Yes, indicate: Carrier: _____ Policy/Group #: _____

Name of dentist/orthodontist: _____ Phone: _____

Name of Family Physician: _____ Phone: _____

PARENT/GUARDIAN AUTHORIZATION

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by me and the examining physician. I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment, and necessary transportation for my child. In the event I cannot be reached in an EMERGENCY I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above.

Signature

Date

*** If for religious reasons you cannot sign this form, the camp should be contacted for a legal waiver which must be signed.*

Required information must be determined locally. This is a record of dates of basic immunizations and most recent booster doses.

Vaccines	Year of basic Information	Year of Last Booster
Diphtheria Pertussis (whooping cough) Tetanus	1. 2. 3.	1. 2.
Tetanus, Diptheria = TD Or... _____		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tubercullin test given (most recent)		
Haemophilus Influenza b (HIB)		

The applicant is under the care of a physician for the following condition(s): _____

Current treatment (include current medications): _____

Additional Information (including limitations and/or allergies): _____

Medical examination should be performed within 24 months of arrival at camp. Examination for some other purposes within this period is acceptable.

I have examined the person herein described and have reviewed his/her health history on _____
Date of examination

It is my opinion that he/she is able to engage in all camp activities, except as noted above.

Licensed Physician's Signature: _____ M.D.

Address: _____

Street and number
City
State
Zip Code

Phone: _____ Date: _____

By* _____
*Initial if completed by nurse or physician's assistant