THE WESTFIELD AREA Y SACC / SUMMER CAMP HEALTH HISTORY

REQUIRED BY THE NJ DEPARTMENT OF HEALTH & SAFETY PRIOR TO ATTENDANCE

Participant's Name: _____ Birth Date: _____ Age: _____ Sex: _____
Last First MI

Address: _____ Phone: _____
Street Town Zip

AUTHORIZED PICK UP / EMERGENCY NOTIFICATION INFORMATION:

P/G 1: _____ Day Phone: _____ Cell #: _____

Relationship: _____ Pick up: Y N Emergency Contact: Y N

P/G 2: _____ Day Phone: _____ Cell #: _____

Relationship: _____ Pick up: Y N Emergency Contact: Y N

Name: _____ Day Phone: _____ Cell #: _____

Relationship: _____ Pick up: Y N Emergency Contact: Y N

Name: _____ Day Phone: _____ Cell #: _____

Relationship: _____ Pick up: Y N Emergency Contact: Y N

Name: _____ Day Phone: _____ Cell #: _____

Relationship: _____ Pick up: Y N Emergency Contact: Y N

Name of family physician: _____ Phone: _____

Name of dentist/orthodontist: _____ Phone: _____

Immunization History: Please record the date (month & year) of the basic immunizations and the most recent booster. If you have questions, check with your doctor. **Physician's signature is NOT required. NO SUPPLEMENTAL SHEETS PERMITTED!**
Dates REQUIRED and must be written on this form.

DPT Booster _____ Tetanus Booster _____ Polio OPV (sabin)_____ MMR _____
Pertussis _____ HBV_____ HIB_____ Varicella_____ Tuberculin Test: _____ Result _____

Health History: (check—giving approximate dates) **Date of last medical examination** _____

Allergies		Diseases		Conditions	
Hay Fever	_____	Chicken Pox	_____	Ear Infections	_____
Poisoning Ivy/Oak	_____	Measles	_____	Heart Defect/Disease	_____
Insect Stings	_____	German Measles	_____	Convulsions	_____
Penicillin	_____	Mumps	_____	Diabetes	_____
Drugs	_____	Asthma	_____	Bleeding Disorders	_____

Food / Medication Allergies: _____

Will you be sending an asthma inhaler? _____ Will you be sending an Epipen? _____

Operations or serious injuries (dates): _____

Chronic or recurring illness including seizures: _____

List all medications that your child is currently taking: _____

Are there any activities in which your child should NOT participate? _____

Please describe any current physical, mental or psychological conditions requiring medication, treatment or restrictions :

_____

IMPORTANT: **PLEASE NOTIFY THE Y IF THIS CHILD HAS BEEN EXPOSED TO ANY COMMUNICABLE DISEASE**

HEALTH POLICY: In case of injury, participant's own personal insurance policy will cover medical costs. **The YMCA does *not* provide medical insurance**

Do you carry family medical insurance? Y__N__ If yes then Carrier _____ Policy/Group #_____

PARENT'S AUTHORIZATION: This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed activities except as noted by me. The person herein has had a physical examination by his/her doctor within the last year and is in good health to participate in Westfield Area Y programs. I hereby give permission to the physician selected by the Program Director or Coordinator to order X-rays, routine tests and treatment for the health of my child in the event of an emergency. I hereby give permission to the physician selected by the Director or Coordinator to emergency transport, hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above in the event of an emergency if I cannot be reached.

Signature of Parent or Guardian: _____ Date: _____

Health Form must be completed and signed at least one month prior to program start date