



# Camp Chesapeake Health Advisory Form

Camper's Name \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Phone (H): \_\_\_\_\_

(W): \_\_\_\_\_

## Health History

(Check all that apply, give dates, last date of Tetanus is required upon Registration)

✓	Health concern	Date	✓	Health concern	Date	✓	Health concern	Date
<input type="checkbox"/>	Ear Infections	<input type="text"/>	<input type="checkbox"/>	Hay Fever	<input type="text"/>	<input type="checkbox"/>	Chicken Pox	<input type="text"/>
<input type="checkbox"/>	Rheumatic fever	<input type="text"/>	<input type="checkbox"/>	Poison Ivy	<input type="text"/>	<input type="checkbox"/>	Measles	<input type="text"/>
<input type="checkbox"/>	Convulsions	<input type="text"/>	<input type="checkbox"/>	Insect stings	<input type="text"/>	<input type="checkbox"/>	Mumps	<input type="text"/>
<input type="checkbox"/>	Diabetes	<input type="text"/>	<input type="checkbox"/>	Penicillin	<input type="text"/>	<input type="checkbox"/>	Asthma	<input type="text"/>
<input type="checkbox"/>	Behavior*	<input type="text"/>	<input type="checkbox"/>	Psychological* Conditions	<input type="text"/>	<input type="checkbox"/>	<b>Tetanus shot (REQUIRED)</b>	<input type="text"/>

\* Please list on back any behavior or psychological conditions we should be aware of during camp.

Are there any other medical conditions we should know about? \_\_\_\_\_

### \*\*\*NOTE: Proof of immunization is needed for out of state children\*\*\*

- ⇒ It is required that you notify the camp of exposure to any communicable disease at any time before, or during the camp sessions.
- ⇒ It is suggested that every child get a physical examination by a licensed physician prior to coming to camp. This is suggested rather than required. If you do get a physical, please forward a doctors note to camp.

**Parent's Authorization:** This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the examining physician. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the YMCA Camp Director to hospitalize and secure proper treatment for my child as named above. I also give my permission for said child to participate in all camp activities.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Primary Health Insurance Provider: \_\_\_\_\_

Child's Primary Physician: \_\_\_\_\_ Phone # \_\_\_\_\_