



FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

# YMCA CAMP REED

## 2021 HEALTH HISTORY / PARENT PERMISSION FORM DUE JUNE 1, 2021

Any changes to this form should be provided in writing upon participant's arrival at camp.  
Please provide complete information so that Camp is aware of participant's needs.

### PLEASE INDICATE PROGRAM

TRAD. WEEK # \_\_\_\_\_  
CIT GROUP # \_\_\_\_\_  
 Staff  JC

Participant's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Boy \_\_\_ Girl \_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Grade ('21/'22 school year): \_\_\_\_\_ Age as of July 1, 2021: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact #1 \_\_\_\_\_ Relationship \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Add'l Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact #2 \_\_\_\_\_ Relationship \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Add'l Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**\*\*Parent/guardian will be contacted first in an emergency. If parent/guardian is unavailable, emergency contacts will be called.**

### MEDICAL INFORMATION (please write "N/A" if not applicable)

Name of family physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name of family dentist/orthodontist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### **PAYMENT INFORMATION (Required at clinic or hospital for any medical treatment)**

**Please indicate method of payment. A method MUST be chosen from the following:**

Self-pay: Please indicate name and address of person responsible for payment: \_\_\_\_\_

Private Insurance: Name of primary insured: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_

Carrier or Plan Name: \_\_\_\_\_ Group#: \_\_\_\_\_ ID#: \_\_\_\_\_

Medicaid (Molina, Apple Health, etc.): **Please ATTACH A COPY of participant's current Medicaid card**

### ***\*IMPORTANT - PHYSICAL SIGNATURE MUST BE PRESENT FOR PARTICIPANT TO ATTEND***

As parent or legal guardian, I agree to release and hold harmless the YMCA of the Inland Northwest and YMCA Camp Reed, their agents, assistants, employees and co-sponsors for any damage or injuries, physical or mental, which may occur as a result of my child's participation in activities in connection with YMCA Camp Reed programs. I understand and certify that participation in YMCA Camp Reed activities is completely voluntary and I have had the opportunity to familiarize myself with the camp program and activities in which my child will be engaging. I recognize that certain hazards and dangers are inherent in YMCA Camp Reed programs and particularly but not limited to, the activities of archery, arts and crafts, BB marksmanship, biking, boating, day and night hiking, horseback riding, pottery, high and low ropes courses, rock climbing wall, rappelling, riflery, sports, swimming, waterfront games, and 1-7-mile overnight hiking trips. I further understand that 13-14-year-old campers may take a 20-mile overnight bike trip which travels on public roads and that the CIT bike trip is 200 miles on public roads. All activities are more fully described on the YMCA Camp Reed website and program information, which I agree to read. I recognize the importance of knowing and abiding by YMCA Camp Reed's rules, regulations and procedures for the safety of camp participants. I acknowledge that although YMCA Camp Reed has taken safety measures to minimize the risk of injury to participants, YMCA Camp Reed cannot insure or guarantee that the participants, equipment, premises and/or activities will be free of all hazards, accidents or injuries. I understand that it is my responsibility to provide health insurance for my child. I certify that my child's information, as I have provided, is correct and complete as far as I know, and it is my opinion that my child is physically, emotionally and mentally able to engage in all camp activities, except as specifically noted. I hereby give permission to the YMCA Camp Reed staff to provide routine health care, dispense prescribed and over-the-counter medications, and seek emergency medical or dental treatment including ordering x-rays or tests deemed necessary by the health care providers. I give permission to the YMCA Camp Reed staff to arrange necessary transportation. In the event I cannot be reached in an emergency, I hereby give permission to the medical provider selected by YMCA Camp Reed staff to secure and administer treatment, including hospitalization, for my child. If there are any changes to health information provided for my child, I agree to provide the camp nurse with updated and accurate information IN WRITING at the time of check in. I agree to the release of any records necessary for insurance purposes. I agree to allow the YMCA and YMCA Camp Reed to use my child's image for YMCA and YMCA Camp Reed publicity and marketing purposes. This completed form may be photocopied or reproduced for trips out of camp.

Signature of participant, or parent/guardian if under 18: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**PRINT BOTH PAGES, SIGN HERE & RETURN**

Printed Name \_\_\_\_\_

**MEDICAL INFORMATION PAGE 2**

Participant's Name: \_\_\_\_\_

PLEASE NOTE: If your participant has special health needs (including but not limited to: diabetes, cardiac illness, severe asthma, seizures, serious behavioral issues, or severe allergies), you must contact the camp director for advance clearance. On a case-by-case basis, we consult with parent/guardian and our camp health care provider to determine if accommodation and appropriate care is available.

PLEASE MARK ALL BUBBLES (a response is needed for each). Attach additional sheet if more explanation is needed.

- |            |                           |                          |                           |                            |                          |
|------------|---------------------------|--------------------------|---------------------------|----------------------------|--------------------------|
| Asthma     | <input type="radio"/> Yes | <input type="radio"/> No | ADD/ADHD                  | <input type="radio"/> Yes  | <input type="radio"/> No |
| Migraines  | <input type="radio"/> Yes | <input type="radio"/> No | Cardiac Defect/Disease    | <input type="radio"/> Yes  | <input type="radio"/> No |
| Bedwetting | <input type="radio"/> Yes | <input type="radio"/> No | Crohn's Disease           | <input type="radio"/> Yes  | <input type="radio"/> No |
| Diabetes   | <input type="radio"/> Yes | <input type="radio"/> No | Serious Behavioral Issues | <input type="radio"/> Yes* | <input type="radio"/> No |
| Seizures   | <input type="radio"/> Yes | <input type="radio"/> No | Conditions Not Listed     | <input type="radio"/> Yes* | <input type="radio"/> No |

\* Please describe \_\_\_\_\_

1. Describe any other significant PAST medical treatment or history \_\_\_\_\_

2. Describe any CURRENT physical, developmental, or psychological conditions requiring medication, treatment, special restrictions, or considerations while at camp \_\_\_\_\_

3. Is the participant presently under the care of a physician for any conditions? Yes No

Name and phone number of treating physician \_\_\_\_\_

Explain \_\_\_\_\_

4. Describe any camp activities from which the participant should be exempted for health or developmental reasons \_\_\_\_\_

5. Has the participant been diagnosed with COVID-19 in the past 90 days? **Yes** **No**

If yes, contact Camp Director to discuss advance clearance and to determine participation in pre-camp COVID testing.

6. Diet Accommodations? \* Nut Free Gluten Free Vegetarian

\*Camp Reed can accommodate these special diets listed above. For discussion of additional diet accommodations, please contact the Camp Director prior to session.

**PRESCRIPTION MEDICATIONS**

Participant takes medication? Yes No

If yes, please note:

At check-in, present any prescription medications and fill out a medication instruction card detailing dosage and frequency.

- Place in **original prescription bottle**, only enough for the length of camp. Do not refrain from sending meds if participant takes them at home.
- Our onsite camp nurse dispenses all prescription medications. **No medications of any type are allowed with participant or in the cabins.**
- Last dispensing of medications is Friday lunch.

**NON-PRESCRIPTION MEDICATIONS (mark a response for each)**

Utilizing medical history and discretion, camp health care provider will administer the following non-prescription medications in case of illness or injury. I authorize the following non-prescription medications to be administered to participant by the camp health care provider as needed:

- |   |   |   |   |
|---|---|---|---|
| <u>Acetaminophen (Tylenol)</u> <input type="radio"/> Yes <input type="radio"/> No | <u>Cough syrup</u> <input type="radio"/> Yes <input type="radio"/> No | <u>Antacid</u> <input type="radio"/> Yes <input type="radio"/> No | <u>Ibuprofen</u> <input type="radio"/> Yes <input type="radio"/> No |
| <u>Loratadine (Claritin)</u> <input type="radio"/> Yes <input type="radio"/> No   | <u>Benadryl</u> <input type="radio"/> Yes <input type="radio"/> No    | <u>Sudafed</u> <input type="radio"/> Yes <input type="radio"/> No |   |

**ALLERGIES: LIST ALL KNOWN (Medications, food, environmental, etc.) Attach a separate sheet if needed.**

Allergy	Check all that apply	Describe severity, typical reaction, and a preferred response
_____	<input type="checkbox"/> airborne / <input type="checkbox"/> ingested / <input type="checkbox"/> contact	_____
_____	<input type="checkbox"/> airborne / <input type="checkbox"/> ingested / <input type="checkbox"/> contact	_____

**IMMUNIZATION HISTORY (MANDATORY):** Is the participant current with the following:

Polio Yes No    Mumps Yes No    Rubella Yes No    Diphtheria Yes No    Pertussis Yes No    Measles Yes No

Date of last Varicella (chicken pox): month/year \_\_\_\_\_ Disease Vaccine

Is Tetanus immunization current? Yes -Month/year \_\_\_\_\_ No

If camper is **not vaccinated**, please provide a Washington State Immunization Exemption form to YMCA Camp Reed by June 1, 2021. If your pediatrician and you participate in the online Washington Immunization Record, you can access your immunization information online at: [wa.myir.net](http://wa.myir.net)

# LETTER TO MY COUNSELOR AT YMCA CAMP REED

*Camper completes this side. Parent/guardian completes opposite side (pg. 4).*      CAMP SESSION: \_\_\_\_\_

Dear Counselor,

My name is \_\_\_\_\_ . My friends call me \_\_\_\_\_ .

I am \_\_\_\_\_ years old. In Fall 2021 I will be in the \_\_\_\_\_ grade. My birthday is \_\_\_\_\_ .

I have \_\_\_\_\_ brother(s), age(s) \_\_\_\_\_ . I have \_\_\_\_\_ sister(s), age(s) \_\_\_\_\_ .

The things I like to do for fun are \_\_\_\_\_

I am good at \_\_\_\_\_

I am coming to Camp Reed because \_\_\_\_\_

I hope to be able to do the following things at Camp Reed this summer: \_\_\_\_\_

When I am at Camp Reed I don't want to \_\_\_\_\_

I get along with friends who \_\_\_\_\_

Last summer I \_\_\_\_\_

I would also like you to know: \_\_\_\_\_

**See you soon!**

\_\_\_\_\_  
Signature

# LETTER TO MY CAMPER'S COUNSELOR AT YMCA CAMP REED

Guardian completes this side. Camper completes opposite side (pg.3).

Mail, fax, email or drop off this form & health history form.

YMCA Camp Reed 1126 N Monroe Spokane, WA 99201

P 509 777 9622 | F 509 343 4096 | [CampReed@ymcainw.org](mailto:CampReed@ymcainw.org)

Name of camper: \_\_\_\_\_

Camper's pronouns: (e.g. "they/them") \_\_\_\_\_

Dear Counselor,

This is my camper's \_\_\_\_\_ year at summer overnight camp and \_\_\_\_\_ at Camp Reed.

I want my camper to go to camp because \_\_\_\_\_.

While at camp, I hope they \_\_\_\_\_.

*My camper is...*

...most happy when \_\_\_\_\_.

...most unhappy when \_\_\_\_\_.

...enthusiastic about \_\_\_\_\_.

...not fond of \_\_\_\_\_.

...apt to be afraid of \_\_\_\_\_.

He/she is \_\_\_\_\_ at taking care of personal belongings.

What behaviors do you most often have to speak to your camper about? \_\_\_\_\_

What methods of correcting these behaviors have you found effective? \_\_\_\_\_

My camper lives with (please name): Parent(s)/Guardian(s) \_\_\_\_\_

Brother(s) \_\_\_\_\_ Sister(s) \_\_\_\_\_ Others \_\_\_\_\_

My camper has the following responsibilities at home: \_\_\_\_\_

My camper is allergic to:

Allergy	Check all that apply	Describe severity, typical reaction, and a preferred response
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_____	<input type="checkbox"/> airborne / <input type="checkbox"/> ingested / <input type="checkbox"/> contact	_____
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_____	<input type="checkbox"/> airborne / <input type="checkbox"/> ingested / <input type="checkbox"/> contact	_____
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Does your camper have a learning, emotional, or behavioral condition? If yes, please explain: \_\_\_\_\_

Anything else you would like us to know? \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

( ) \_\_\_\_\_ - \_\_\_\_\_  
Cell phone number

( ) \_\_\_\_\_ - \_\_\_\_\_  
Secondary phone number

**\*\*If there is something of special importance or concern, please speak directly to your camper's counselor at check-in.**