FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

YMCA OF CENTRAL FLORIDA
CAMP WEWA HEALTH HISTORY FORM

PARTICIPANT INFORMATION

Participant Name _____

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. **This form MUST be completed BY A LICENSED MEDICAL PERSONNEL and mailed to the Camp Office two weeks prior but not more than 6 months prior to camper's attendance at camp.**

Mail this form to:
YMCA Camp Wewa
221 S. Binion Road
Apopka, FL 32703
P 407-886-1240

PROGRAM PARTICIPANT INFORMATION

Participant's First Name _____ MI _____ Last _____

Date of Birth _____ Age _____ Gender ◯ Male ◯ Female

Dates of Camp Attendance _____ _____

_____ _____

_____ _____

RESTRICTIONS

Explain any dietary restrictions for this individual.

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

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GENERAL QUESTIONS (Explain "Yes" answers below.)

Participant Name _____

YES	NO	Has/does the participant:
☐	☐	1. Had any recent injury, illness or infectious disease?
☐	☐	2. Have a chronic or recurring illness/condition?
☐	☐	3. Ever been hospitalized?
☐	☐	4. Ever had surgery?
☐	☐	5. Have frequent headaches?
☐	☐	6. Ever had a head injury?
☐	☐	7. Ever been knocked unconscious?
☐	☐	8. Wear glasses, contacts, or protective eye wear?
☐	☐	9. Ever had frequent ear infections?
☐	☐	10. Ever passed out during or after exercise?
☐	☐	11. Ever been dizzy during or after exercise?
☐	☐	12. Ever had seizures?
☐	☐	13. Ever had chest pain during or after exercise?
☐	☐	14. Ever had high blood pressure?
☐	☐	15. Ever been diagnosed with a heart murmur?
☐	☐	16. Ever had back problems?
☐	☐	17. Ever had problems with joints (e.g. knees, ankles, etc.)?
☐	☐	18. Have an orthodontic appliance being brought to camp?
☐	☐	19. Have any skin problems (e.g., itching, rash, acne, etc.)?
☐	☐	20. Have diabetes?
☐	☐	21. Have asthma?
☐	☐	22. Had mononucleosis in the past 12 months?
☐	☐	23. Had problems with diarrhea/constipation?
☐	☐	24. Have problems with sleepwalking?
☐	☐	25. If female, have an abnormal menstrual history?
☐	☐	26. Have a history of bed-wetting?
☐	☐	27. Ever had an eating disorder?
☐	☐	28. Ever had emotional difficulties for which professional help was sought?

Please explain any "yes" answers, noting the number of the questions.

_____

_____

_____

_____

_____

_____

Which of the following has the participant had?

☐ Measles ☐ Chicken Pox ☐ German Measles ☐ Mumps ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C

Date of last TB Mantoux Test _____ Result: ☐ Positive ☐ Negative

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IMMUNIZATIONS

Participant Name _____

Please give all dates of immunization for:

Vaccine	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year
DTP						
TD (tetanus/diphtheria)						
Tetanus						
Polio						
MMR						
or Measles						
or Mumps						
or Rubella						
Haemophilus influenza B						
Hepatitis B						
Varicella (Chicken Pox)						

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

_____

_____

_____

_____

_____

_____

HEALTH CARE RECOMMENDATIONS

I examined this individual on _____/_____/_____

(YMCA Camp Wewa requires an annual exam, no more than 12 months before participant arrives at camp.)

BP _____ Weight _____ Height _____

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

_____

_____

_____

_____

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RECOMMENDATIONS & RESTRICTIONS AT CAMP

Participant Name _____

Treatment to be continued at camp

_____

Medications to be administered at camp (name, dosage, frequency)

_____

Any medically-prescribed meal plan or dietary restrictions

_____

Known allergies

_____

Description of any limitations or restriction on camp activities

_____

Additional information for health care staff at the camp

_____

Signature of Licensed Medical Personnel _____

Printed Name _____ Date _____

Title _____ Phone _____

Address _____

FOR CAMP USE ONLY | SCREENING RECORD

Date Screened ____/____/____ Time _____ ☐ AM ☐ PM

Meds Received _____

_____

Updates/Additions to Health History Noted ☐ Yes ☐ No ☐ None required

Current Health Needs Identified _____

_____

Observational Notes _____

_____

Screened By _____