

Complete and Return by APRIL 30, 2008

Camp Manito-wish YMCA

P.O. Box 246

Boulder Junction, WI 54512 Fax (715) 385-2461

We use this information to: (a) Provide healthcare staff with background about your child; (b) Educate administrative and counseling staff about camper needs; (c) Brief the kitchen staff about diet needs.

Receiving this information prior to your child's arrival is crucial to our ability to provide a supportive environment.

Boys 8-day (June 15 - June 22) Girls 8-day (August 6 - August 13) Outpost Session (name of trip/session):
Boys 14-day (1) (June 15 - June 28) Girls 14-day (1) (July 16 - July 29)
Boys 14-day (2) (June 30 - July 13) Girls 14-day (2) (August 6 - August 19)
Boys 20-day (June 24 - July 13) Girls 20-day (July 16 - August 4) Leadership Adventure Boys Girls

Camper Name Birth date

Complete Address Home Phone

Parent/Guardian Names

Complete Address

Phone #s: Contact Name Contact Name
Home: (if different) Home: (if different)
Work () Cell () Work () Cell ()

Emergency Contact: If parents cannot be reached or are traveling, this person needs to be ready to assume responsibility and care for the camper in the event he/she needs to leave camp due to behavior, injury, or illness.

Name Relationship

Address

Phone: Home () Work () Cell ()

PLEASE NOTE: Each participant is responsible for any medical expenses and should be covered by his/her own sickness and accident insurance.

Is camper covered by any hospitalization/medical care policy? YES NO

Insurance Co. Name

Complete Address

Subscriber Name

Policy or Certificate #

Does insurance co. require pre-authorization? YES NO Phone ()

PARENT SIGNATURE REQUIRED:

I, the undersigned, being the custodial parent/guardian of, a minor under the age of 18 years, hereby give my express consent for my son or daughter to participate in the Camp Manito-wish YMCA program. By giving this consent, I expressly acknowledge that I have been made aware that my child may be exposed to the risks of nature and the elements over which neither the Camp nor its employees have control. Having been informed of such risks, I specifically agree that my child may participate in the program. If my child is participating in the Outpost program, I specifically give my permission for my child to cross an international border(s), should the trip be so routed.

I hereby give permission to the physician selected by the camp director to order X-rays, routine tests, and treatment for the health of my child, and in the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director, or to any medical facility, to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. I understand the information on this form will be shared on a "need to know" basis with camp staff. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status. I accept responsibility for medical/surgical treatment charges which may be incurred on my child's behalf.

Parent/ Signature Date



Health History Record for Camper

Name _____

To be filled out by parent/guardian of camper

IMPORTANT -- When Completing this Form Please Note:

- Every item in every section must be completed. Mark N/A if any section is not applicable to you.
- Keep a photocopy of this medical form for your records.

Family Physician _____ Phone () _____

Family Dentist _____ Phone () _____

Orthodontist _____ Phone () _____

Past and Present Medical Problems

CONDITIONS AND SYMPTOMS: Please check any of the following which are applicable either presently or at any other point in the past.

	YES	NO	Recovered		YES	NO	Recovered
1. Asthma	___	___	___	17. Sleep Problems	___	___	___
2. Allergies	___	___	___	a. Active Bedwetting	___	___	___
a. Medications	___	___	___	b. Trouble falling asleep	___	___	___
b. Foods	___	___	___	c. Sleep (Walking/talking/snoring)	___	___	___
c. Environmental	___	___	___	18. Mental/Emotional Health Problems	___	___	___
d. Anaphylactic Reaction	___	___	___	a. Learning Disability	___	___	___
3. Broken Bones	___	___	___	b. Attention Deficit Disorder (ADD)	___	___	___
4. Shoulder Problems	___	___	___	c. ADHD	___	___	___
5. Knee Problems	___	___	___	d. Depression	___	___	___
6. Ankle Problems	___	___	___	e. Obsessive Compulsive Disorder	___	___	___
7. Back Problems	___	___	___	f. Substance Abuse	___	___	___
8. Eating Disorders	___	___	___	g. Anxiety Disorder	___	___	___
9. Skin Problems (rash, acne)	___	___	___	20. Poison Ivy Reaction	___	___	___
10. Cold Sores	___	___	___	21. Reaction to Insect Bite	___	___	___
11. Headaches	___	___	___	22. Reaction to Drug	___	___	___
12. Dizziness	___	___	___	23. Seizure Disorder	___	___	___
13. Fainting	___	___	___	24. Bleeding Disorders	___	___	___
14. Menstrual Cramps	___	___	___	25. Diabetes	___	___	___
15. Head Injury (Concussion)	___	___	___	26. Heart Murmur	___	___	___
16. Mononucleosis	___	___	___	27. Positive TB Test	___	___	___
				Cardiac Disease	___	___	___
				28. Other	___	___	___

If you have answered "yes" to any of the above items, please give a detailed explanation of how you deal with it at home.

ITEM #	DETAILED DESCRIPTION

FAMILY HISTORY: Have there been any changes in your family history/situation? (divorce, death, etc.)

MEDICATIONS:

Please send only prescription medications which your child is currently using (within the last 4 months). **Prescriptions must be in original containers.** We supply all necessary over-the-counter medications for common ailments and illnesses. Should your child be prescribed a medication while at Camp, it will be called in (and paid for by you in advance) to the pharmacy at the Marshfield Clinic (715-358-1000) in Minocqua or the Walgreens location in Woodruff, WI.