CAMP FITCH YMCA HEALTH FORM

LICENSED MEDICAL PERSONNEL PORTION "FORM 2"

(2014 update)

Please return completed form to:
Camp Fitch YMCA
12600 Abels Rd
North Springfield, PA 16430
fax to 814-922-7000 or
email a .pdf to info@campfitchymca.org

To Parent(s)/Guardian(s): **Complete this section** and **give this form "FORM 2" and a copy of your completed CAMP FITCH YMCA HEALTH FORM "FORM 1"** to your child's health care provider.

Dates will attend camp: from _____ (Month/Day/Year) to _____ (Month/Day/Year)

Camper Name: _____ (First) _____ (Middle) _____ (Last)

◯ Male ◯ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp _____

Camper home address: _____

_____ (City) _____ (State) _____ (Zip Code)

Parent/guardian name & phone: _____ (_____)_____

Parent/Guardian stop here. Rest of form to be completed by medical personnel.

Medical Personnel: Please review the CAMP FITCH YMCA HEALTH FORM "FORM 1" and complete all remaining sections of this form "Form 2". Attach additional information if needed.

Physical exam done today: ◯Yes ◯No (If No, date of last physical: _____ (Month/Day/Year))

ACA accreditation standards specify physical exam within last 12 months.

Weight: _____ lbs Height: _____ ft _____ in Blood Pressure _____ /_____

Allergies: ◯No Known Allergies
- ◯To foods (list):
- ◯To medications (list):
- ◯To the environment (insect stings, hay fever, etc. – list):
- ◯Other allergies (list):

Describe previous reactions:

Many non-prescription medications are in stock at Camp Fitch YMCA and are used on an as needed basis to manage illness and injury. Please list any medications the camper should **not** be given: (Examples include acetaminophen, ibuprofen, diphenhydramine, cough drops, calamine lotion, bismuth subsalicylate, and hydrocortisone 1% cream.)

_____
_____
_____
_____

Diet, Nutrition: ◯Eats a regular diet. ◯Has a medically prescribed meal plan or dietary restrictions (describe below):

The camper is undergoing treatment at this time for the following conditions (describe below): ◯None

Medication: ◯No daily medications. ◯Will take the following prescribed medication(s) while at camp (name, dose, frequency–describe below):

Other treatments/therapies to be continued at camp (describe below): ◯None needed

Do you feel that the camper will require limitations or restrictions to activity while at camp? ◯No ◯Yes

If you answered "Yes" to the question above, what do you recommend? **(describe below, attach additional information if needed)**

I have reviewed the CAMP FITCH YMCA HEALTH FORM "FORM 1", and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)

Name of licensed provider (please print): _____ Title: _____

Signature: _____

Office address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Telephone: (_____) _____ Date: _____

Camper Name _____ (First) _____ (Middle) _____ (Last)

Dates Attending _____