

# Athens Y Camps

## HEALTH EXAMINATION FORM

Year \_\_\_\_\_

Check the appropriate boxes:  Athens Y Camp  Camp Chattooga  
 Day  Traditional  Adventure  LIT  Staff  
Attending Session(s) (circle) 1 2 3 4 5 6 7 8

### SECTION A SECTION A TO BE COMPLETED BY PARENT/GUARDIAN AND SIGNED

Name \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Business Ph. \_\_\_\_\_

Home Address \_\_\_\_\_ Home Ph. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Second Parent or Guardian or Emergency Contact \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Business Ph.( ) \_\_\_\_\_

If not available in an emergency, notify \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Business ( ) \_\_\_\_\_

### NO CHILD WILL BE ACCEPTED AS A CAMPER WITHOUT HEALTH INSURANCE OR OFFICIAL PROOF OF MEDICAID

(Please attach a copy of your health insurance card)

FRONT

BACK

#### PARENT/CAMPER AGREEMENT:

This health history is correct so far as I know, and the child named above has permission to engage in all prescribed camp activities except as noted. The staff of the Athens "Y" camps exercise caution in the conduct of all camp activities; however, they do not assume responsibility for accidents, injury, or illnesses suffered by its campers.

I, as a parent or guardian of the child named above, individually and on behalf of the camper, hereby release, discharge, and agree to indemnify the Athens "Y" Camps, their directors, and employees from all liability for damage, injury or illness to the camper or their property relating to or deriving from their stay at the Athens "Y" Camps or participation in or travel to or from the Athens "Y" Camps activities.

I, as a parent or guardian of the child named above, hereby grant permission for the Athens "Y" Camps to use any photographs of the camper taken during the camping session in newspapers, magazines, or brochures or other media for promotional purposes.

#### AUTHORIZATION FOR TREATMENT:

I, as a parent or guardian of the child named above, hereby give permission to the medical or dental personnel selected by the camp to order X-rays, routine tests, treatment for camper and necessary transportation for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, order injections, anesthesia, or surgery, including hospitalization for the child named above. The completed forms may be photocopied for trips out of camp. I further acknowledge that I will be responsible for payment of all charges related to the medical or dental services provided.

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_

Date \_\_\_\_\_

Allergies to drugs \_\_\_\_\_

Any other known allergies \_\_\_\_\_

Recent exposure to contagious disease yes \_\_\_\_\_ no \_\_\_\_\_

If yes, name disease and date \_\_\_\_\_

List: serious or chronic illnesses that the child has ever had and operations or serious injuries.

**Name of Camper** \_\_\_\_\_

HEALTH HISTORY – Does your child have any of the following? For all yes answers please mark “x” in the box and explain in the space provided, include your usual method of treatment and have your child bring to camp the medication required.

- |  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> high blood pressure                                   | <input type="checkbox"/> sleepwalking           | <input type="checkbox"/> frequent sore throats | <input type="checkbox"/> seizures        | <input type="checkbox"/> stomach upsets            |
| <input type="checkbox"/> reactions to insect bites / stings / poisonous plants | <input type="checkbox"/> bedwetting             | <input type="checkbox"/> bronchitis            | <input type="checkbox"/> fainting spells | <input type="checkbox"/> ear problems              |
| <input type="checkbox"/> other   | <input type="checkbox"/> skin rashes / problems | <input type="checkbox"/> asthma                | <input type="checkbox"/> ADHD            | <input type="checkbox"/> hayfever / sinus problems |
|  |   | <input type="checkbox"/> diabetes              | <input type="checkbox"/> ADD             |  |

List medicines taken daily / dosages: \_\_\_\_\_

List medicines taken when necessary / dosages: \_\_\_\_\_

Describe any other health conditions requiring treatment or restrictions: \_\_\_\_\_

**SECTION B SECTION B TO BE COMPLETED BY PHYSICIAN AND SIGNED**

Every child is required to have a medical examination performed by a physician within 12 months prior to camp attendance. Section B must be signed and completed by a physician at that time.

Date of examination: \_\_\_\_\_

General condition or Appraisal: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Allergies: Animals \_\_\_\_\_ Food \_\_\_\_\_

Drugs \_\_\_\_\_ Other \_\_\_\_\_

List any current or on-going treatment and/or medications: \_\_\_\_\_

\_\_\_\_\_ I believe this child is able to attend camp and participate in all camp activities

\_\_\_\_\_ I believe this child is able to attend camp and participate in all camp activities with the following restrictions and recommendations:

Examining Physician Name: \_\_\_\_\_ Signature: \_\_\_\_\_ M.D.

Address: \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_\_

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Which of the following has your child had? <input type="checkbox"/> Measles <input type="checkbox"/> Chicken pox <input type="checkbox"/> German measles <input type="checkbox"/> Mumps <input type="checkbox"/> Hepatitis	<b>IMMUNIZATION RECORD</b> (to be completed by parent or physician) Please send a copy of the immunization record or complete below, listing the last date vaccine was given:  DTP/DPTA _____ Tetanus _____ Polio _____ MMR _____ Hepatitis B _____
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**Return Completed Form to: Athens Y Camp for Boys • P.O. Box 8 • Tallulah Falls, GA 30573  
Camp Chattooga for Girls • P.O. Box 70 • Tallulah Falls, GA 30573**