New England Sports Camps & Alfond Youth Center

CAMPER HEALTH HISTORY FORM

Mandatory for Residential Campers.

My Camper is Attending (please circle one):

Baseball Camp (ages 7-10)	Baseball Camp (ages 10-12)	Premier Baseball Camp	Softball Camp
Football Camp	Sport Karate Camp	Lacrosse Camp Camp	Swim Camp
	Field Hockey (ages 9-13)		

Last Name	First Name	DOB	Age at Camp	Gender
Parent/Guardian Name	Parent/Guardian Phone	Parent/Guardian Phone		
Parent/Guardian Name	Parent/Guardian Phone	Parent/Guardian Phone		
Emergency Contact Name	Emergency Contact Phone	Emergency Contact Phone		
Mailing Address	City	State	Zip Code	
Email Address	Email Address			

Please list any **ALLERGIES** that our staff should be aware of (medication, food, insects).

Please list any **DIETARY RESTRICTIONS** that your child may have (vegetarian, vegan, gluten free, etc.).

Physical **RESTRICTIONS** (please familiarize yourself with the activities that will take place at camp):

_____ My child has **no** physical restrictions for camp activities.

_____ My child has physical restrictions for camp activities. Please describe below:

Medical Insurance Information

Insurance Company _____ Policy Number _____

Subscriber Name _____

Health Care Providers

Primary Doctor _____ Phone _____

Dentist _____ Phone _____

Orthodontist _____ Phone _____

Boys & Girls Clubs and YMCA of Greater Waterville at the Alfond Youth Center
126 North Street, Waterville, Maine 04901 P: 207-873-0684 F: 207-861-8016
Clubaycc.org facebook.com/aycmaine twitter.com/aycmaine

Camp Tracy & New England Sports Camps
(Physical Address) 302 McGrath Pond Road, Oakland, Maine
camptracy.org newenglandsportscamps.org

New England Sports Camps & Alfond Youth Center

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Mandatory for Residential Campers.

Camper Name _____ **DOB** _____

MEDICATION

_____ This camper will **NOT** take any daily medications while at camp. _____ This camper will take daily medications while at camp (list below).

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. Please review camp instructions about required packaging/containers. The AYC and New England Sports Camps require original pharmacy containers with the camper's name and medication instructions. Medication should be provided only the in the amounts sufficient to last through the entirety of camp.

Name of Medication	Date Started?	Reason for taking the med	What time of day? (breakfast, lunch, dinner, bedtime, other)	Amount/dose to give.	How the med is given? (orally, injection, etc.)

These non-prescription medications listed below may be available to your child, under the discretion of the on-site Emergency Medical Technician (EMT) or dedicated staff supervisor in charge of dispensing medications. These over-the-counter medications will be used on an as-needed basis to manage illness and injury. **Please cross out any that staff does not have permission to administer your camper.**

Acetaminophen (Tylenol)

Aloe

Antibiotic cream (topical)

Antihistamine / allergy medication

Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

Sore throat spray

Hydrocortisone cream

Ibuprofen (Advil or Motrin)

Laxatives for constipation (Ex-Lax)

Calamine Lotion

Diphenhydramine antihistamine/allergy medicine (Benadryl)

Parent/Guardian Authorization for Health Care

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give permission to hospitalize, secure proper treatment form, and order injection, anesthesia or surgery for this child. I understand information on this form will be shared on a "need to know" basis with camp staff. I give permission to photo copy this form. 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 programs' staff about my child's health status.

_____ _____ _____

Signature of Parent/Guardian | Date | Relationship to Camper

NESC MEDICATION FORM

Please fill out one form for each medication. This includes and prescription, vitamins, and over-the-counter drugs your child will be taking daily at Camp. Everything must be brought to Camp in its original container.

Camper Name:_____Medication Name:_____

Time(s) of day given:_____

Dosage given:_____

Camp Medical Staff Only

Date	Time	Dose	Initial

NESC MEDICATION FORM

Please fill out one form for each medication. This includes and prescription, vitamins, and over-the-counter drugs your child will be taking daily at Camp. Everything must be brought to Camp in its original container.

Camper Name:_____Medication Name:_____

Time(s) of day given:_____

Dosage given:_____

Camp Medical Staff Only

Date	Time	Dose	Initial

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Mandatory for Residential Campers.

Camper Name _____ **DOB** _____

GENERAL HEALTH HISTORY

	Yes	No		Yes	No
1. Ever been hospitalized?			11. Had fainting or dizziness?		
2. Ever had surgery?			12. Passed out/had chest pain during exercise?		
3. Have recurrent/chronic illness?			13. Had mononucleosis ("mono") during the past year?		
4. Had a recent infectious disease?			14. If female, have problems with periods/ menstruation?		
5. Had a recent injury?			15. Have problems with falling asleep/sleepwalking?		
6. Had asthma/wheezing/shortness of breath?			16. Ever had back/joint problems?		
7. Have diabetes?			17. Have a history of bedwetting?		
8. Had seizures?			18. Have problems with diarrhea/constipation?		
9. Had headaches?			19. Have any skin problems?		
10. Wear glasses, contacts or protective eyewear?			20. Traveled outside the country in the past 9 months.		

If you answered **YES** to any of the above questions, please provide further details below. For travel outside the country, please name the countries visited and the dates of travel.

Mental, Emotional & Social Health (please answer yes or no for each statement)

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?
3. During the past 12 months, seen a professional to address mental/emotional health concerns?
4. Had a significant life event that continues to affect the camper's life? (history of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain YES answers in the space below, noting the number of the question. The camp may contact you for additional information.

Parent/Guardian Authorization for Healthcare

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or the examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. 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.

Signature of Parent/Guardian _____ Date _____

New England Sports Camps & Alfond Youth Center

CAMPER HEALTH HISTORY FORM

Mandatory for Residential Campers.

Camper Name _____ **DOB** _____

Immunization History Provide the month and year for immunizations. Starred (*) immunizations must be current. **Copies of immunization forms from health-care providers or state or local government are acceptable, please attach to this form.**

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis* (DTaP) or (TdaP)						
Tetanus booster * (dT) or (TDaP)						
Mumps, measles, rubella * (MMR)						
Polio * (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCB)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) _____ Had chicken pox _____ Date						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date	Negative	Positive

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

_____ _____ _____

Signature of Parent/Guardian Date Relationship to Camper

New England Sports Camps & Alfond Youth Center

CAMPER HEALTH HISTORY FORM

Mandatory for Residential Campers.

Camper Name _____ **DOB** _____

THIS PAGE IS TO BE COMPLETED BY A PHYSICIAN

Copies of a recent sports/camp physical form from health-care providers are accepted in place of this page.

Physical Exam Completed Today: _____ Yes ____ No (If no, date of last physical ____/____/____/)

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

Allergies _____ no known allergies

If the child has allergies, please select from the options below, list the specifics and describe the reactions:

____ Food Allergies

____ Medicine

____ The environment (insect stings, hay fever, etc.)

____ Other

Diet & Nutrition _____ This camper eats a regular diet

_____ has a medically prescribed meal plan or dietary restrictions (describe below):

This camper is undergoing treatment at this time for the following conditions (describe below):

____ OR None

Medication _____ no daily medications _____ Will take the following medication(s) while at camp
(please list name, dose, frequency - describe below)

Other treatments/therapies to be continued at camp (describe below): _____ none needed

Do you feel 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 discussed the camp program with the camper's parent/guardian . It is in 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) _____ **Signature** _____

Office Address _____ **City** _____ **State** _____ **Zip Code** _____

Phone Number _____ **Date** _____

ALFOND YOUTH & COMMUNITY CENTER, NEW ENGLAND SPORTS CAMPS, CAMP TRACY AND SUMMER ENRICHMENT PROGRAM

Epi Pen & Inhaler Permission Form

This form needs to be completed in order for your child to keep their Epi Pen and/or Inhaler with them during Camp. If it is not completed the Epi Pen and/or Inhaler will be kept by a staff person who if with your child.

Camper Last Name	**Camper First Name**
DOB	**Epi Pen** _____ **Inhaler** _____

My child has permission to carry his/her Epinephrine Auto-Injector and/or Asthma Inhaler while in the care of the AYCC, NESC, CT, or SEP programs.

_____

Printed Name Parent/Guardian

_____ _____

Signature of Parent/Guardian Date

A Licensed Medical Professional must complete the bottom section of this form.

Name of Medication(s)	
Date of Medication Order	
Route & Dosage of Medication	
Frequency & Time of Medication Administration/Assistance	
Specific recommendations for administration (what type of symptoms would indicate need for medication?)	
Diagnosis and any other medical conditions requiring medication.	
Any special side effects, contraindications and adverse reactions to be observed?	

I hereby verify that _____ has a valid prescription and the knowledge and skills to safely possess and use the following medication while in the care of the AYCC.

_____ _____ _____

Physician's Office Name Office Address Phone

_____ _____ _____

Physician's Name Physician's Signature Date

Boys & Girls Clubs and YMCA of Greater Waterville

at the **Alfond Youth & Community Center**

126 North Street, Waterville, Maine 04901

AYCC
Alfond Youth & Community Center