



# Tracking Out Camp Seafarer Trip Health History Form



Camper's Name: \_\_\_\_\_ Name Called: \_\_\_\_\_  
First Middle Last

Male  Female Previous Sea Gull/Seafarer camper:  No  Yes \_\_\_\_\_

**If Yes, how many years at camp?**

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Age at Camp: \_\_\_\_ **Years** \_\_\_\_ **Months** Grade \_\_\_\_ School \_\_\_\_\_

Mother's Name: _____	Father's Name: _____
Home Phone: (____) _____	Home Phone: (____) _____
Work Phone: (____) _____	Work Phone: (____) _____
Cell Phone: (____) _____	Cell Phone: (____) _____

**In the case of separation or divorce, both sets of information are required.**

If neither parent can be reached, in case of emergency notify \_\_\_\_\_

Relationship \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ ext. \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

**HEALTH HISTORY:** Please check  and attach a separate statement regarding potential problem areas:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Recurring Strep Throat              | <input type="checkbox"/> Heart Disorder                         | <input type="checkbox"/> Serious Injuries | <input type="checkbox"/> Frequent Ear Infections  |
| <input type="checkbox"/> Sleep Walking                       | <input type="checkbox"/> Severe Headaches/Migraines             | <input type="checkbox"/> Chronic Cough    | <input type="checkbox"/> Bed Wetting              |
| <input type="checkbox"/> Hepatitis                           | <input type="checkbox"/> Asthma/Wheezing                        | <input type="checkbox"/> Fainting         | <input type="checkbox"/> Infectious Mononucleosis |
| <input type="checkbox"/> Chronic Constipation                | <input type="checkbox"/> Seizures                               | <input type="checkbox"/> Tuberculosis     |   |
| <input type="checkbox"/> ADD/ADHD Learning Disabilities      | <input type="checkbox"/> Kidney Problem/Urinary Tract Infection |   |   |
| <input type="checkbox"/> Chicken Pox - Date of Disease _____ |   |   |   |
| <input type="checkbox"/> Other _____                         |   |   |   |

**Allergic Reactions:** (Please give details)

Insect Stings \_\_\_\_\_ Poison Ivy/Oak \_\_\_\_\_

Drugs \_\_\_\_\_ Food \_\_\_\_\_

Other \_\_\_\_\_

Has your child been evaluated or received treatment or counseling by a psychologist or physician for an emotional or behavioral problem, including hyperactivity?  No  Yes If yes, on a separate statement, please help us understand how to effectively address these concerns. Are there other special concerns regarding your child's medical history? (attach a separate statement if necessary)

**NOTE:**

- Please write or call the camp if your child is exposed to or has contracted any potentially serious communicable diseases (such as chicken pox, hepatitis, meningitis, etc.) during the three weeks prior to camp attendance.
- In order to complete the registration process, this form (no substitutions) must be received one week prior to program start date.
- Final acceptance is subject to review by the Camp Medical Committee and the Director reserves the right to rescind enrollment based upon recommendation of medical staff.

**PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR HEALTH INSURANCE CARD**

**PERMISSION TO EXAMINE, PRESCRIBE MEDICATION AND TREAT:** I hereby give permission to the registered nurse or physician selected by the camp director to perform routine tests and treatment for the health of my child. In the event of an emergency or other acute event where time will not allow me to be reached, or I cannot be reached, I hereby give permission for the Camp physician to secure necessary consultative care for my child, including hospitalization, anesthesia, surgery, and other medical treatment.

**PERMISSION TO DISCLOSE INFORMATION:** I agree to allow the Camp Physician or Health Clinic Director to speak with the Camp Director and Camp personnel living or working with my child, regarding any medications my child is taking, as well as specific medical or psychological conditions that may impact my child's daily living.

**PERMISSION TO RELEASE RECORDS:** I authorize the Camp Physician or Health Clinic Director to release any health records related to my child as may be necessary for treatment, referral, billing, or insurance purposes.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_



## Tracking Out Camp Seafarer Trip Authorization to Administer Medication

As we plan for another great season at Camp Seafarer, the Health Center would like to make the administration of medication brought from home an efficient and thorough process. The Authorization to Administer Medication Form will assist us in this process.

If you plan to send or bring medication from home for your camper, please take careful note that no medication can be allowed in the camper's cabin except for rescue inhalers. All medication must be turned in on Opening Day. At check-in the YMCA staff will properly secure and verify that medication is labeled from the pharmacy with the correct name, correct dosage, and times of administration. Send only medication that is properly labeled. The Health Center is fully stocked with a variety of over-the-counter medications; "just-in-case" medications are not necessary. Your daughter/son will have access to the Health Center 24 hours a day.

In order to speed your medication drop-off, we are giving you the enclosed form to complete in advance. When you and your physician have agreed on the medications your camper will need at camp, please hand the completed form to your child's YMCA Track Out Director prior to the trip or send by fax to (252) 249-2259. The convenient time at camp to administer medications are breakfast and dinner. At these times campers are easily reminded to take their meds. Bedtime meds will be administered by a nurse in the cabin; however, Protopin injections need to be monitored at the Health Center in the evenings.

Here are a few hints to assist with completing the form:

- **Name of medication:** Name and strength of the medication. Examples are Ritalin 10mg or Concerta 36mg.
- **Dosage:** Number of pills and total amount. For instance, if you get Ritalin 10mg pills in the morning and your total dose is 15mg then your dosage is 15mg or 1 ½ pills. If you are on Ritalin 15mg in the a.m. and you get 1 Ritalin 10mg and 1 Ritalin 5mg, then list these separately on the form.
- **Times taken:** As previously stated, we strongly recommend breakfast, dinner or bedtime. However, you may write in an off-time med. Please supply in the days if the med is only Monday or every other day or M/W/F, etc. If the medication is "just as needed" then cross out the times and write "as needed".
- **How given:** By mouth, inhaled, eye drops, eardrops, or topical.
- **Duration:** Duration refers to the length of time the med is going to be given. If it is an antibiotic write "until finished". If it is a routine med then write "camp".
- Finally, please indicate if it would be OK for the medication not to be administered on closing day.

Thank you for your cooperation. Our Health Center Staff is looking forward to a healthy and safe spring.

Head Nurse, Track Out Camp

**(See the next page for Authorization to Administer Medication Form.)**

# Tracking Out Camp Seafarer Trip Authorization to Administer Medication

**PART 1: TO BE COMPLETED BY PARENT/GUARDIAN**

I hereby request and authorize Camp Seafarer personnel to administer prescribed medication as directed by our physician. I agree to release and hold harmless Camp Seafarer and any of their officers, staff members or agents from lawsuit, claim, demand, or action, etc. against them, for administering prescribed medication to this camper provided Camp Seafarer and staff follow the orders as written below.

Camper \_\_\_\_\_ Birth Date \_\_\_\_\_ Session \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Date \_\_\_\_\_

**Please Note:** Dosages must be consistent with dosage labels. In the event of inconsistency, the product’s label dosage will be followed.

Name of Medication	Dosage	Time Taken (please circle)	How Given	Duration
		9 a.m., 1 p.m., 7 p.m., Bedtime		
		9 a.m., 1 p.m., 7 p.m., Bedtime		
		9 a.m., 1 p.m., 7 p.m., Bedtime		
		9 a.m., 1 p.m., 7 p.m., Bedtime		
		9 a.m., 1 p.m., 7 p.m., Bedtime		
		9 a.m., 1 p.m., 7 p.m., Bedtime		
		9 a.m., 1 p.m., 7 p.m., Bedtime		
		9 a.m., 1 p.m., 7 p.m., Bedtime		
		9 a.m., 1 p.m., 7 p.m., Bedtime		
		9 a.m., 1 p.m., 7 p.m., Bedtime		

**INDICATIONS:**

For the safety of campers, all medication will be kept in the Health Center and dispensed by the Health Center Staff including over-the-counter medications. The only exceptions to this rule are Inhalers, Epipens, and some dermatological preparations.

**PART 2: TO BE COMPLETED BY CAMP SEAFARER HEALTH CENTER STAFF**

Check as appropriate:

- Part 1 above is completed including signatures.
- Prescription medicine is properly labeled by a pharmacist.
- Medication to be given and physician order is consistent.
- Over the counter medication is in an original container with the manufacturer’s dosage and safety seal intact.
- No over-the-counter medication was sent to camp.

Camp Nurse’s Signature \_\_\_\_\_ Date \_\_\_\_\_



# Tracking Out Camp Seafarer Trip Parental Consent and Code of Conduct

## Parental Consent:

I hereby give my permission for \_\_\_\_\_ to travel with the YMCA Staff to Camp Seafarer for the dates listed below:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> <b>Track 1</b> | Sept. 20–22, 2011 (Finley and Kerr)                       | <input type="checkbox"/> <b>Track 3</b> | May 1–3, 2012 (Finley and Kerr)         |
|   | Sept. 27–29, 2011 (Cary, Garner, Kraft)                   |   | May 8–10, 2012 (Cary, Garner, Kraft)    |
| <input type="checkbox"/> <b>Track 2</b> | Aug. 30–Sept. 1, 2011 (Cary, Finley, Garner, Kerr, Kraft) | <input type="checkbox"/> <b>Track 4</b> | April 3–5, 2012 (Finley and Kerr)       |
|   |   |   | April 10–12, 2012 (Cary, Garner, Kraft) |

I understand that my child will be transported by a YMCA bus and supervised by YMCA personnel. I also understand that I am responsible for the actions and conduct of my child during the trip. In the event of an emergency in which I cannot be reached, I give permission for Emergency Medical Staff and the YMCA to take appropriate action in the best interest of my child/ward.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

In case of Emergency, please contact \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Alternate Contact \_\_\_\_\_ Relationship to participant \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Special Needs? \_\_\_\_\_

## Participant Code of Conduct:

As a guest at a YMCA function, I understand that my child is required to stay under the supervision of the YMCA Staff at all times. I understand that my child will be on my best behavior and represent the YMCA and myself in a positive and appropriate manner throughout the trip. My child will also remain in the designated areas at all times and follow the instructions of the YMCA staff. I completely understand that any alcoholic beverages, tobacco products, illegal drugs and anything else deemed inappropriate by the YMCA will result in immediate dismissal from the trip, as well as any future YMCA functions/events.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_