Summer Programs Health Form

CONTINUED...

Medications: Please list all medications (including over-the counter or nonprescription drugs taken on a routine basis) that you are sending with your child to camp. Medications must be in ORIGINAL CONTAINERS (if a prescription medication, child's name must be listed on the bottle) with specific instructions for proper dispensing. Send enough medication to last the entire length of camp. Over-the-counter and nonprescription drugs need to be labeled with camper's name. Any medications sent to camp without written instructions will not be administered to the camper. Attach additional pages as needed.

__ This person takes NO medications on a routine basis AND NO medications have been sent to camp with this person.

__ This person takes medications as follows and it may be administered by camp staff:

Medication: ______________________________ Used for: ___________________________
Amount/dosage: _________________________ Time Taken: ________________________

Medication: ______________________________ Used for: ___________________________
Amount/dosage: _________________________ Time Taken: ________________________

Medication: ______________________________ Used for: ___________________________
Amount/dosage: _________________________ Time Taken: ________________________

Please identify any medications taken during the school year that child does/may not take during the summer:

____
____

Insurance Information: If you carry family insurance, please complete this section.

Policy or Group Number: ______________________________ Name of Carrier: _____________________
Phone of Carrier: ____________________________________
Name of Insured: _____________________________________ Relationship: _______________________

Medical, Dental & Accident insurance are the responsibility of each particiapnt and their parent or guardian. The rogue Valley Family YMCA does not provide this coverage.

Family Medical Professionals:

Name of Doctor: ______________________________________ Phone: ___________________________
Name of Dentist: ______________________________________ Phone: ___________________________
Name of Orthodontist: _________________________________ Phone: ___________________________
Name of Specialist: ___________________________________ Phone: ___________________________

RELEASE, WAIVER AND INDEMNITY AGREEMENT: I understand that the YMCA assumes no responsibility for injuries or illness that I may sustain as a result of my physical condition or resulting from my participation in any YMCA activity. I hereby (and on behalf of my children) release, discharge and agree not to sue the YMCA, its employees, officers, or directors for any and all claims for injury, illness, death, loss or damage that I may suffer as a result of my participation. I agree that I will cooperate and conform to the directions and instructions of the YMCA staff and volunteers. I hereby give the YMCA permission to use their judgment in obtaining medical service for myself and/or my child. I give permission to the physician selected by the YMCA personnel to render medical treatment deemed necessary and appropriate. Payment of any resulting medical, hospital or related costs and expenses must be paid by my insurance or available benefit plan of mine or my spouse. I have read and understand this Release, Waiver and Indemnity Agreement.

_ Check here if you do not want your child's image used in promotional materials

Parent/Guardian Signature ____Date____________

Please Return to:
Rogue Valley Family YMCA Child Care Office:
522 West Sixth Street, Medford, OR 97501
www.rvymca.org
Billing Questions: 772-6295 ext 214

Summer Programs Health Form

CHILD'S INFORMATION:

Child's Name____ DOB____________Age______

Home Address______________________________________ Home Ph #________________

Billing/Mailing Address____

City/State____________________________Zip_________E-mail________________________

Gender: ❒ female ❒ male YMCA member: ❒ yes ❒ no School________________________

PARENT/GUARDIAN CONTACT INFORMATION:

Child Lives with: ❒ Both Parents ❒ Mother ❒ Father ❒ Other

Guardian #1_________________________ Guardian #2___________________________

Employer___________________________ Employer______________________________

Work Phone_________________________ Work Phone____________________________

Cell ______________________________ Cell _________________________________

EMERGENCY CONTACT(S): OTHER THAN PARENTS AUTHORIZED TO PICK-UP

Name_______________________ Relationship_________________Phone__________________

Name_______________________ Relationship_________________Phone__________________

Name_______________________ Relationship_________________Phone__________________

Name_______________________ Relationship_________________Phone__________________

MEDICAL: Please list any medical conditions that you think may be helpful for the summer staff to know about (things like recent surgeries, healing injuries, or ongoing conditions needing special attention).

ALLERGIES: Please list any and all allergies, such as bee stings, food, or other.

Has your child ever been stung by a bee? ❒ YES ❒ NO

DIETARY RESTRICTIONS: Please list any and all dietary modifications.

PHYSICAL LIMITATIONS: Please list any limitations and reasons for all listed limitations.

OTHER: Please use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the staff should be aware.

NON-PRESCRIPTION MEDICATIONS The following over-the-counter medications can be administered as needed.

❒ Sunscreen ❒ Sunburn relief spray/cream (Solarcaine, etc.) ❒ Ibuprofen (Advil)

❒ Acetaminophen (Tylenol) ❒ Calamine/Caladryl Lotion (for insect bites, posion oak reactions)

❒ Other: ______________________________ ❒ Other: __________________________