



# Dubuque Y Health History, Emergency Contact, and Release Form

Last Name:																					Middle Initial:			
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First Name:																					Birth Date (MMDDYY):						
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Street \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Not Specified \_\_\_\_\_ Identifying Marks: \_\_\_\_\_ Grade entering in Fall 2022: \_\_\_\_\_

### Parent or Guardian Information

Parent or Guardian _____	Parent or Guardian _____
Address _____ (Only if different from address above)	Address _____ (Only if different from address above)
Phone _____ Work _____	Phone _____ Work _____
Cell Phone _____	Cell Phone _____
Email _____	Email _____

### Please list at least one emergency contact that, if necessary, could provide transportation home.

Emergency Contact _____	Emergency Contact _____
Cell Phone _____ Work _____	Cell Phone _____ Work _____

### Allergies

<b>Insect Bite/Bee Sting</b>	Yes (circle one) No	Reaction _____	Severity: Mild – Moderate – Severe (circle one)
<b>Sunscreen</b>	Yes (circle one) No	Reaction _____	Severity: Mild – Moderate – Severe (circle one)
<b>Food</b>	Yes (circle one) No	Reaction _____	Severity: Mild – Moderate – Severe (circle one)
<b>Seasonal</b>	Yes (circle one) No	Reaction _____	Severity: Mild – Moderate – Severe (circle one)
<b>Medications</b>	Yes (circle one) No	Reaction _____	Severity: Mild – Moderate – Severe (circle one)
<b>Other</b>	Yes (circle one) No	Reaction _____	Severity: Mild – Moderate – Severe (circle one)

Please explain/specify any of the above that were answered "Yes" (i.e. type of food allergy, medication associated, etc.) \_\_\_\_\_

**If medications will be administered at camp for above allergies a "Medication Information Form" must be completed**

### Physician Information

Name of family physician: \_\_\_\_\_ Phone: \_\_\_\_\_

### Insurance Information

Insurance Carrier: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_ Policy/ Group #: \_\_\_\_\_

**Immunization History:** Iowa requires a **Certificate of Immunization** for all campers and staff.   
 You may use the form provided or a copy from your doctor's office. **Check if attached.**  
 Permission to treat in case of emergency

Camper or Staff Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**Relevant Past Medical History, General Information, and Restrictions**

Does your child (or staff member) have Asthma? **Yes (circle one) No**

\*Will your child (or staff member) be bringing an inhaler to camp? **Yes (circle one) No**

Are there any physical, mental, or psychological conditions requiring medication, treatment, or restrictions while at camp?

\*Does your child or (staff member) take any prescription or over-the-counter medication at home? **Yes (circle one) No**

Please list any past medical treatment or recent injuries: \_\_\_\_\_

Describe any specific activities from which your child (or staff member) should be exempted: \_\_\_\_\_

Any dietary modifications or restrictions? **Yes (circle one) No** Please explain: \_\_\_\_\_

Does your child have an IEP or 504 plan? **Yes (circle one) No** Does your child qualify for free or reduced lunch? **Yes (circle one) No**

Please circle the ethnic group the child most identifies with (**circle one**): Caucasian/White African American/Black Hispanic/Latino  
Native Hawaiian or other Pacific Islander American Indian or Alaska Native Other \_\_\_\_\_

Does your child attend a YMCA Afterschool or Early Education program? **Yes (circle one) No** If yes, where? \_\_\_\_\_

Are there any accommodations or services that we can provide to make the summer as successful as possible? \_\_\_\_\_

Does your child participate in ELL services? **Yes (circle one) No** Primary language spoken at home: \_\_\_\_\_

**Authorizations:**

Accuracy of Information: This health history is correct so far as I know and the person herein described has permission to engage in all camp activities except as noted.

Authorization for Treatment: In case of an emergency, I authorize the YMCA to administer first aid and to transport my child or (staff member) to the nearest hospital emergency room and to order X-rays; routine tests and treatment; and to release any records necessary for insurance purposes. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director, or his/her \*

designee, to secure and administer treatment, including hospitalization, for the person named above. This form can be photocopied for camp trips.

Authorization for Medications/Topical Ointments: I authorize the YMCA Health Staff and its designees to administer the following medications (on an "as needed" basis unless contraindicated): Acetaminophen (Tylenol), Ibuprofen (Motrin/Advil), Antacid (Tums), Diphenhydramine HCl (Benadryl), sunscreen, and Anti-Itch Creams.

Acknowledgment of Risk and Waiver: I understand and acknowledge my camper (or staff member) may participate in a variety of activities including; swimming, boating, outdoor games, sports, rope course, off-site activities, field trips, and other rigorous physical activities. I hereby release and discharge, and agree to indemnify and hold harmless the Dubuque Y, and their officers, directors, members, agents, employees, volunteers, and any other persons or entities on their behalf, against all claims, demands, and causes of actions whatsoever, either in law or equity, relating to or arising from any participation, medical treatment, recommendation, transportation or administration, or any lack thereof.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Photo Release: I authorize the Dubuque Y and American Camp Association to have my child's (or staff members) photo to appear in camp brochures, videos, on websites or other promotional literature.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Parent/Guardian of Camper, Staff Member, or Parent/Guardian of Staff Member under 18 years of Age**