York Community Day Camp 2023

Director: Melissa Stafford

Email: ycdaycamp@gmail.com

Medical Form

IN PREPARATION FOR YOUR CHILD(REN)'S WEEK(S) AT CAMP, WE ASK THAT YOU PLEASE SEND THE COMPLETED MEDICAL FORM WITH YOUR REGISTRATION. THIS INFORMATION IS ESSENTIAL AND NEEDED BY THE CAMP DIRECTOR. Complete ALL health and insurance information, please do not leave any blanks, either put N.A. (not applicable) or NONE or NONE KNOWN, whatever the case may be.

Return form to: Messiah United Methodist
1300 N. Beaver Street
York PA, 17404

Camper Name_____ Age_____

Birthdate_____

(CIRCLE) Male Female Grade completed_____

Parent/Guardian #1 _____

Address_____

City_____ State_____ Zip_____

Parent Email_____

Home Phone _____ Work Phone _____

Cell Phone _____

Parent/Guardian #2 _____

Address_____

City_____ State_____ Zip_____

Parent Email_____

Home Phone _____ Work Phone _____

Cell Phone _____

Alternate Emergency Contact

Name _____Relationship_____

Contact Phone # _____

Please list any and all persons the camper may be released to (including parents/guardians)

Name	Relationship

Health Insurance Co._____

ID/Policy #_____Group #_____

Name of primary care physician _____

Phone #_____

Date of last physical _____Current Height_____ Current Weight_____

Describe if the camper has any special needs (attach paper if needed)

_____

List any medications the camper is currently taking or has taken in the last year (attach paper if needed)

_____

List any of those medications that will be administered during camping hours (attach paper if needed)

_____

List any medications the camper is allergic to

_____

What kind of allergic reaction?

_____

Are there any non-prescription medications you DO NOT want your child to receive?

_____

Please circle one:

Has camper had a tetanus shot in the past five years? (Circle) YES NO

Has camper ever had hepatitis? (Circle) YES NO

Has camper ever had a history of behavioral or emotional problems? (Circle) YES NO

If yes, please describe on a separate piece of paper.

Circle all that apply and explain as necessary

Allergies	Asthma	Learning Disability
Nose Bleeds	Bleeding/Clotting Disorder	Homesickness
Convulsions/Epilepsy	Ear Infections	Eye/Vision Problem
Braces (other than on teeth)	ADHD	Depression
Ear/Hearing Problem	Fainting	Anxiety
Hear Defect/Disease	Bronchitis	Hypertension
Vegetarian	Reaction to Insect Stings	Diabetes
Swimmer's Ear	Car/Motion Sickness	Other:

Explanation_____

_____

Chronic or Recurring
Illness_____

_____

Disabilities_____

_____

Limitations or suggestions regarding activities_____

_____

Describe campers swimming ability _____

_____

Any other condition requiring medication, special care or special diet _____

_____

Is there any other information about the camper that we should know about to help make his/her transition into camp easier? (First time away from home, other than with family, etc.?)

_____

_____

If your child/youth has been taken off medications for the summer by you, the parent/guardian, we highly recommend those medications be taken during their time at camp so your child/ren will have a quality experience.

Parent Authorization: This health history and other information requested are accurate to the best of my knowledge. The child herein described has permission to engage in all prescribed camp activities, except as noted. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child. I have read and fully understand this statement.

Parent/Guardian Signature_____

Printed name_____

Relationship to Camper_____

Date Completed_____