

**FORM PACK**

**THESE FORMS MUST BE  
COMPLETED AND RETURNED  
TO THE MONTCLAIR YMCA,  
25 PARK STREET  
BEFORE THE START  
OF YOUR CHILD'S  
1<sup>ST</sup> CAMP SESSION**

**FOR SAFETY REASONS,  
A CAMPER CANNOT BE PERMITTED AT CAMP  
UNLESS WE HAVE THESE FORMS ON FILE**

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# **MANDATORY**

- **HEALTH FORM**

The Health Form is required by NJ State Law and does not require visiting a doctor. Immunization information must be filled out in full; children will not be allowed to attend until all appropriate information is provided. Waivers for persons requesting exemptions from medical examinations or medical treatment must be requested. **Please be sure to inform the camp directors with any changes in emergency or health information #'s that occur over the summer.**

- **MEDICATION AUTHORIZATION**

If your child requires medication during the camp day, complete the enclosed form and have it signed by your physician. Medications must be sent in original prescription containers. No plastic baggies or other containers!

You must authorize the camp health director to administer over the counter medications and suntan lotion by signing attached form. **Sun block is unable to be applied without signed parent authorization.** Parents will be contacted prior to the medication being administered when possible.

## **FORMS OPTIONAL DEPENDING ON CAMPERS NEEDS**

- **AFTER CAMP CARE AUTHORIZATION SHEET**      *(Mandatory for After Campers Only)*

Only needs to be completed if your child is attending the after camp program.

- **WALK HOME PERMISSION SLIP**

Only for children 10 years of age or older, or sibling of older child.

PLEASE PRINT & WRITE LEGIBLY ON ALL FORMS AND INCLUDE ALL INFORMATION. EXTRA FORMS ARE AVAILABLE AT THE MONTCLAIR YMCA FRONT DESK.



**WALK HOME PERMISSION SLIP**

***(CHILD MUST BE 10 YEARS OR OLDER)***

I \_\_\_\_\_ give permission for \_\_\_\_\_ to  
(Parent's Name) (Camper's Name)

walk home from his/her assigned bus stop. My child is over 10 years of age.

Campers Name: \_\_\_\_\_ Bus Stop: \_\_\_\_\_

Birth date: \_\_\_\_\_

Village/Age: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**THE MONTCLAIR YMCA IS NOT RESPONSIBLE FOR YOUR CHILD  
ONCE THEY LEAVE THE BUS STOP**

*(Optional Form)*

**WALK HOME PERMISSION SLIP**

***(CHILD MUST BE 10 YEARS OR OLDER)***

I \_\_\_\_\_ give permission for \_\_\_\_\_ to  
(Parent's Name) (Camper's Name)

walk home from his/her assigned bus stop. My child is over 10 years of age.

Campers Name: \_\_\_\_\_ Bus Stop: \_\_\_\_\_

Birth date: \_\_\_\_\_

Village/Age: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**THE MONTCLAIR YMCA IS NOT RESPONSIBLE FOR YOUR CHILD  
ONCE THEY LEAVE THE BUS STOP**

(Fill out only if in After Care Program at Hillside School)

**MONTCLAIR YMCA AFTER CAMP PROGRAM**

1. Child's Information:

Child's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

2. Parent/Guardian Information:

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Cell/Beeper #'s: \_\_\_\_\_ Cell/Beeper #'s: \_\_\_\_\_

3. Emergency Contact: (other than parents)

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relation to Child: \_\_\_\_\_ Relation to Child: \_\_\_\_\_

Cell/Beeper #'s: \_\_\_\_\_ Cell/Beeper #'s: \_\_\_\_\_

4. Person authorized to pick-up from After Camp Care: **(ID Necessary)**

**\*In addition to those listed above\***

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Cell/Beeper #: \_\_\_\_\_ Cell/Beeper #: \_\_\_\_\_

Relation: \_\_\_\_\_ Relation: \_\_\_\_\_

5. IMPORTANT YMCA POLICIES:

- a. After Camp pick-up is by 6:30 p.m. If you are unable to be at the Hillside School by that time, please make arrangements for one of your authorized persons to pick up your child.
- b. I understand that late pick-up after 6:30 p.m. will entail a late fee of \$10.00 per child per 10 minute increments.
- c. I understand that my child must be signed out everyday before leaving the Hillside School.

I have read the above policies and completed the information needed.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**\*All Children must be signed out by parent & may not be taken directly from bus.**

# CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Mail this form to the address below by \_\_\_\_\_ (date)

Dates will attend camp: from \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Camper Name: \_\_\_\_\_  
First Middle Last

Male  Female Birth Date \_\_\_\_\_ Age on arrival at camp: \_\_\_\_\_  
Month/Day/Year

**To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.**

- 1) Complete pages 1, 2 and 3 of this form (FORM 1) and make a copy.
- 2) Send the original, signed FORM 1 to camp by the requested date.
- 3) Complete the top of FORM 2 (CAMPER HEALTH-CARE RECOMMENDATIONS) and provide the copy of FORM 1 with FORM 2 to your child's health-care provider for review and completion.
- 4) After it has been completed and signed by your child's health-care provider, return FORM 2 to camp by the requested date.

Camper Home Address: \_\_\_\_\_  
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) (\_\_\_\_\_) \_\_\_\_\_  
Relationship to Camper  
 Email: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) (\_\_\_\_\_) \_\_\_\_\_  
Relationship to Camper  
 Email: \_\_\_\_\_

Additional contact in event parent(s)/guardian(s) can not be reached:

Name(s): \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_ Preferred Phones: (\_\_\_\_\_) (\_\_\_\_\_) \_\_\_\_\_  
Relationship to Camper

**Allergies:**  No known allergies.  This camper is allergic to:  Food  Medicine  The environment (insect stings, hay fever, etc.)  Other  
*(Please describe below what the camper is allergic to and the reaction seen.)*

**Diet, Nutrition:**  This camper eats a regular diet.  This camper eats a regular vegetarian diet.  
 This camper has special food needs. *(Please describe below.)*

**Restrictions:**  I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.  
 I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. *(Please describe below.)*

**Medical Insurance Information:**

This camper is covered by family medical/hospital insurance  Yes  No

*Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.*

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Subscriber \_\_\_\_\_ Insurance Company Phone Number (\_\_\_\_\_) \_\_\_\_\_

**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 my permission to the physician 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 Custodial Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Camper: \_\_\_\_\_

*If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

Camper Name

First

Middle

Last

(For Camp Use) Cabin or Group

(For Camp Use) Session Code(s):



# CAMPER HEALTH HISTORY FORM 1

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Camper Name: \_\_\_\_\_  
First Middle Last

Birth Date: \_\_\_\_\_  
Month/Day/Year

**General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.**

Has/does the camper:

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

**Please explain "Yes" answers in the space below,** noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

**Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.**

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? .....  Yes  No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?.....  Yes  No
3. During the past 12 months, seen a professional to address mental/emotional health concerns?.....  Yes  No
4. Had a significant life event that continues to affect the camper's life?.....  Yes  No  
(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 questions. The camp may contact you for additional information.

**Health-Care Providers:**

Name of camper's primary doctor(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Name of dentist(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_  
Name of orthodontist(s): \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

**What Have We Forgotten to Ask? Please provide in the space below** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. **Attach additional information if needed.**

**Parents/Guardians: STOP here. The rest of this is form is completed when the camper arrives at camp. Keep a copy for your records.**

**CAMPER HEALTH-CARE RECOMMENDATIONS  
by LICENSED MEDICAL PERSONNEL FORM 2**

Developed and reviewed by: American Camp Association,  
American Academy of Pediatrics Council on School Health, &  
Association of Camp Nurses

Mail this form to the address below by \_\_\_\_\_ (date)

**To Parent(s)/Guardian(s): Complete this section and give this form (FORM 2) and a copy of your completed CAMPER HEALTH HISTORY FORM (FORM 1) to your child's health-care provider for review.**

Dates will attend camp: from \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Camper Name: \_\_\_\_\_  
First Middle Last

Male  Female Birth Date \_\_\_\_\_ Age on arrival at camp \_\_\_\_\_  
Month/Day/Year

Camper home address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Custodial parent(s)/guardian(s) phone: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

**Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.**

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. **Medical personnel: Cross out those items the camper should not be given.**

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Phenylephrine (Sudafed PE)
- Pseudoephedrine (Sudafed)
- Chlorpheniramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimate)
- Calamine lotion
- Bismuth subsalicylate (Pepto-Bismol)
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Calamine lotion
- Aloe

**Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.**

**Physical exam done today:**  Yes  No (If "No," date of last physical: \_\_\_\_\_)  
Month/Day/Year

ACA accreditation standards specify physical exam within last 24 months.

Weight: \_\_\_\_\_ lbs Height: \_\_\_\_\_ ft \_\_\_\_\_ in Blood Pressure \_\_\_\_\_ / \_\_\_\_\_

**Allergies:**  No Known Allergies

To foods (*list*):

To medications: (*list*):

To the environment (*insect stings, hay fever, etc.—list*):

Other allergies: (*list*):

**Describe previous reactions:**

**Diet, Nutrition:**  Eats a regular diet.  Has a medically prescribed meal plan or dietary restrictions: (*describe below*)

**The camper is undergoing treatment at this time for the following conditions: (*describe below*)**  None.

**Medication:**  No daily medications.  Will take the following prescribed medication(s) while at camp: (*name, dose, frequency—describe below*)

**Other treatments/therapies to be continued at camp: (*describe below*)**  None needed.

**Do you feel that 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 reviewed the CAMPER HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the camper's parent(s)/guardian(s). It is 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: \_\_\_\_\_ Title: \_\_\_\_\_

Office Address \_\_\_\_\_  
Street City State Zip Code

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_\_