



Camp Manito-wish YMCA

Leadership Program Health History

PARTICIPANT INFORMATION

Name of Participant _____ Preferred Name _____

Program/School Name _____ Grade _____

Birth Date _____ Age _____

Home Address _____

Custodial Guardian #1 _____ Phone Number #1 _____

Custodial Guardian #2 _____ Phone Number #2 _____

In an EMERGENCY, please contact guardians listed above or:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

ACTIVITIES & INTERESTS

What is the participant most looking forward to while they attend the Leadership Program? _____

Are there any physical limitations that would require special consideration for programming at Camp Manito-wish YMCA? Please explain. _____

Are there any activities that the participant should not participate in, including while on trail? _____

Share any behavior concerns and strategies to best support the participant. _____

HEALTH INFORMATION

Has the participant experienced or is presently experiencing:

YES	NO	Medical History	Details – Include severity, action plans and attach any relevant supporting documents.
<input type="checkbox"/>	<input type="checkbox"/>	Allergies (nature, medicine, insects, etc.)	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain, Injury, Surgery	
<input type="checkbox"/>	<input type="checkbox"/>	Neck/Back Pain, Injury, Surgery	
<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Concerns	
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	
<input type="checkbox"/>	<input type="checkbox"/>	Other:	
<input type="checkbox"/>	<input type="checkbox"/>	Other:	

Are the participant's immunizations up to date? (circle one) YES NO

Date of last tetanus shot _____ Date of last physical exam _____

Family Physician _____ Phone _____

Family Dentist _____ Phone _____

In the case of unexpected aches and pains, may over the counter medications (Tylenol, Motrin, Benadryl, etc.) be given? (circle one) YES NO

Do you have medical Insurance? (circle one) YES NO

Insurance Company Name _____ Policy Number # _____

Phone _____

MEDICATIONS

Please send all prescription medications that the participant will need at camp, including any regularly used over the counter medications. Send only the amount of medication needed while at Camp. Send all medications in the original containers with current dosage and schedule.

Permission to dispense medication (please list all prescription and non-prescriptions)

Medication	Dose	Days to be Given	Times to be Given

DIETARY RESTRICTIONS AND FOOD ALLERGIES

Please check all that apply.

- Vegetarian
- Vegan
- Gluten Free
- Dairy Free
- Food Allergy (peanuts, tree nut, lactose, etc.): _____
- Does not eat pork
- Religious Restrictions: _____
- Other: _____

AUTHORIZATION

I authorize Camp Manito-wish YMCA and its designated representative to consent, on my behalf, to emergency medical/hospital care or treatment to be rendered upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization/ treatment rendered pursuant to this authorization.

Printed Name of Participant _____ Date _____

Participant Signature _____

Printed Name of Guardian _____ Date _____

Guardian Signature _____