



Camp Ockanickon
Camp Matollionequay
& Lake Stockwell

Camper Medical History & Medical Examination Form



(Please staple camper photo here)

Complete and mail to: YMCA Camp Ockanickon, Inc. 1303 Stokes Road, Medford, NJ 08055 Phone 609-654-8225

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. The Camper Medical History must be completed by parents/guardians of minors. An update of the Camper Medical History is required annually. The Medical Examination Form must be completed by a licensed medical physician for campers attending overnight camp.

<input type="checkbox"/> Ockanickon for Boys	<input type="checkbox"/> Matollionequay for Girls	<input type="checkbox"/> Lake Stockwell Day Camp
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10

CAMPER INFORMATION *PLEASE PRINT CLEARLY- This is camp's permanent record*

Last Name	First Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB (dd/mm/yyyy)	Age
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FAMILY INFORMATION: *Applies to the Parent/Guardian with whom the camper legally lives.*

Camper Address	Father/Guardian 1 Last Name	Mother/Guardian 2 Last Name
	First Name	First Name
City	Home Phone	Home Phone
State Zip	Work Phone	Work Phone
MEDICAL CONTACTS	Cell Phone	Cell Phone
Family Physician	Employer's Name	Employer's Name
Phone Number	Email (Required)	Email (Required)

Dentist Orthodontist	EMERGENCY CONTACTS: <i>List two contacts other than parent(s)/guardian(s)</i>	
Is the participant covered by family medical/hospital insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name	Name
If so, indicate carrier or plan name	Relationship	Relationship
Group #	Home Phone	Home Phone
ID #	Work Phone	Work Phone
Photocopy of front & back of insurance card must be attached to this form.	Cell Phone	Cell Phone

IMPORTANT- The section below must be completed for camp attendance

This health history is correct and complete as far as I know. The person herein named has the permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide, seek and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. It is my intention that the camp be treated as acting in loco parentis if the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staff member

Printed name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities

Signature of minor or adult camper/staff member _____ Date _____

Camper Medical History & Medical Examination Form

******* RESIDENT CAMPERS: DOCTORS MUST FILL OUT MEDICAL EXAM BELOW AND IMMUNIZATION RECORD MUST BE ATTACHED *******

Camper Last Name First Name

CAMPER MEDICAL HISTORY- To be Completed by the Parent/Guardian

Please list all known food, medicine, or other allergies. (Describe reactions and management of the reactions)

Please list any operation or serious injuries with dates.

Please list any chronic or recurring illness, past medical treatment, psychological conditions or Special Needs.

For girls: Has this camper menstruated?	If no, has the camper been told about it?	If yes, is menstrual history normal?
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Special considerations, suggestions, or reasons the camper or staff member should be exempted from camp activities?

ALL MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER) MUST BE:

- IN THEIR ORIGINAL LABELED CONTAINERS LISTING PATIENT AND DOSAGE
- TURNED IN TO THE HEALTH PROFESSIONAL AT CHECKIN BY THE PARENT/GUARDIAN
- SUFFICIENT IN QUANTITY TO LAST THE ENTIRE STAY AT CAMP

*******RESIDENT CAMPERS ONLY: MEDICAL EXAMINATION- TO BE COMPLETED BY A LICENSED PHYSICIAN *******

This examination must be completed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in camp activities. Laboratory tests done at discretion of physician.

Height	Weight	BP	Resting Pulse	Date Last Tetanus Shot
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Immunizations up to date <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason
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*******ATTACH A COPY OF HEALTH INSURANCE CARD (BOTH SIDES) & IMMUNIZATION RECORD TO THIS DOCUMENT *******

Recommendations and/or restrictions, physical or otherwise, while at camp. Any ongoing treatment or medications

In my opinion, the above applicant is able to participate in an active camp program.

Doctor Name	Date of Exam	Date Signed
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Address	Phone
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Doctor's Signature