

YMCA Camp Ocoee

Health History and Emergency Contacts

Camper Name: _____ Gender: _____ Age: _____

Session(s) Attending: (Check all that apply)

R1 R2 R3 R4 R5 R6 R7 R8

Emergency Contacts:

1) Name: _____ Relationship to Camper: _____

Cell Phone: _____ Home Phone: _____

2) Name: _____ Relationship to Camper: _____

Cell Phone: _____ Home Phone: _____

3) Non-Parent: _____ Relationship to Camper: _____

Cell Phone: _____ Home Phone: _____

Is there any reason to restrict the camper from any camp activity? Yes No

If yes, please explain: _____

Does the camper have any health concerns or special needs? Yes No

If yes, please explain: _____

Are all immunization up to date? Yes No Date of last Tetanus shot: _____

Please list all known allergies (food, medication, other): _____

Does the camper have any dietary restrictions? Yes No

If yes, please explain: _____

Does the camper take any medication on a regular basis, either prescribed or over-the-counter? Yes No

If yes, please explain: _____

The Infirmary stocks a wide variety of over-the-counter (OTC) medications. Please list any OTC medication the camper CANNOT have: _____

Insurance Information (Camp Ocoee does not carry accident or sickness insurance for participants.)

Insurance Company: _____ Address: _____

Policy Number: _____ Group Number: _____

Name of Insured: _____ Policy Holder Insurance ID #: _____

•Photocopy of front and back of health insurance card must be attached to this form

Name of Primary Physician: _____ Phone: _____

Dentist Name: _____ Phone: _____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Additional Sheet Attached

YMCA Camp Ocoee • 111 YMCA Drive • Ocoee, TN 37361
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YMCA CAMP OCOEE

**HAVE YOUR PHYSICIAN OR NURSE PRACTITIONER COMPLETE THIS FORM.
THIS FORM IS REQUIRED FOR PARTICIPATION IN CAMP.**

Medical Recommendation Form (Mandatory)

To Physician/ Nurse Practitioner: This child has enrolled in a summer overnight program at YMCA Camp Ocoee. The program includes physical activity (i.e., swimming, hiking, soccer, climbing). Our healthcare staff uses your information to help meet the health needs of the person described.

Print MD/NP Name: _____	City/State: _____
Office Phone: _____	Date this form was completed: _____

Camper Name: _____ Age: _____ Gender: _____

Session attending: R1 R2 R3 R4 R5 R6 R7 R8

Physical Exam done today: Yes No If No, what is the date of last exam? _____

Camp requires a physical exam within the last 24 months

Sports Physicals meet this requirement

Is this child under the care of a physician for any conditions? Yes No

If yes, please explain: _____

Please describe treatment and/or medication to be continued at Camp Ocoee?

This camper is allergic to: _____

Should exposure occur, how should the reaction be treated? _____

Describe any medically prescribed meal plan or dietary restrictions: _____

Do you feel that the camper will require limitation or restrictions to activity while at camp?

Yes No If yes, please explain: _____

Additional Sheet Attached

Medical Personnel Signature: _____