

PERMISSION TO TREAT

NOTE: KEEP a copy for your records and BRING with you to camp this completed and signed form to YMCA Camp Belknap on your scheduled arrival date. Please DO NOT mail prior to your arrival to camp.

PLEASE READ: This health information is MANDATORY to attend camp. We cannot by law accept a camper without complete health information signed by a parent/guardian and signed by a physician. The information on the following pages is necessary for the care of your child, if he becomes sick or injured at camp. If there are any changes to this health information after it has been submitted, you may discuss these changes on check-in day with the health staff.

IDENTIFYING INFORMATION:

LAST Name: _____ FIRST Name: _____ MI: _____

Date of Birth: ____/____/____ Age (as of June 1, 2012): ____ Social Security #: ____-____-____ Sex: M F
Month Day Year

Parent(s)/Guardian(s): _____ Relationship to child: _____

Home phone: (____) ____ - _____ Business phone: (____) ____ - _____ Cell phone: (____) ____ - _____

Home address:

Number & Street _____ City _____ State _____ ZIP _____ Country _____

If not available in an emergency, please notify: _____

Relationship to camper: _____

Home phone: (____) ____ - _____ Cell phone: (____) ____ - _____

HEALTH HISTORY (attach additional pages if necessary):

Drugs/environmental allergies? Yes No Please list: _____
Dietary modifications? Yes No Please describe and list any substitutes that you will bring to camp: _____

Dietary allergies? Yes No Please list: _____

Disabilities? Yes No Please describe: _____

Chronic/recurring illnesses? Yes No Please describe: _____

Serious injuries/illnesses/operations? Yes No Please describe and provide dates: _____

Chicken pox? Yes No Year: _____

Tetanus booster? Yes No Year: _____

Currently taking medication? Yes No If yes, **complete and sign the Medication Consent form.**

Name of physician: _____ Phone: (____) ____ - _____

Name of dentist: _____ Phone: (____) ____ - _____

Name of orthodontist: _____ Phone: (____) ____ - _____

This health history is correct so far as I know, and the child herein described has permission to engage in all prescribed camp activities, except as noted below.

AUTHORIZATION TO TREAT: I hereby give permission to medical personnel selected by the camp directors to order x-rays, routine tests, treatment, and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp directors to secure and administer treatment, including hospitalization, for the child named above. This completed form may be photocopied for trips out of camp.

Signature PARENT/GUARDIAN (staff member if over 18) _____ DATE: ____/____/____

If for religious reasons you cannot sign this form, you should contact YMCA Camp Belknap to obtain a legal waiver, which must be signed before camp attendance is permitted.

MI:

First:

Last:

CAMPER NAME (PLEASE PRINT)

MEDICATION CONCENT/HEALTH CONCERNS FORM

Camper's Name _____ Birthdate _____

MEDICATION CONSENT: This form is required if your son is on ANY medications (signature required at end of this section). Please mail this form to YMCA Camp Belknap, PO Box 1546, Wolfeboro NH 03894 **NO LATER THAN JUNE 1, 2012.** You do not need to send if he is not on any medication and/or there are no health concerns that we need to be aware of prior to your son's arrival. **If there are any changes to this health information after it has been submitted, you may discuss these changes on check-in day with the health staff.**

This section should be filled out for prescription and **over the counter medications** to be taken at camp **ON A REGULAR BASIS** (attach additional pages if necessary):

	Name of Medication	Dosage/Route	Number of times/day	Reason
1.				
2.				
3.				
4.				
5.				

This section should be filled out for prescription and **over the counter medications** to be taken at camp **ON AN AS NEEDED BASIS** (attach additional pages if necessary):

	Name of Medication	Dosage/Route	Number of times/day	Reason
1.				
2.				
3.				
4.				
5.				

Signature PARENT/GUARDIAN for consent to give medications listed above

DATE: ____/____/____

Please use the back of this sheet to provide any other information that would be helpful to the health staff and/or your son's cabin leader:

MEDICATION CONCERN/HEALTH CONCERNS FORM
