

2010 Medical History Form

Name _____ Date of Birth ____/____/____ Date _____

IMMUNIZATIONS and TESTS

If one or more of the required medical immunization(s) is deemed detrimental to this child's health, attach a certificate specifying which immunization(s) and complete and sign medical exemption statement on back form.

DPT	1 st / /	2 nd / /	3 rd / /	Booster / /	Booster / /
ORAL POLIO	1 st / /	2 nd / /	3 rd / /	Booster / /	Booster / /
Hib (conjugate preferred)	1 st / /	2 nd / /	3 rd / /	4 th / /	
Hepatitis B	1 st / /	2 nd / /	3 rd / /		
MMR	1 st / /	2 nd / /			
Varacella	/ /				

Type	Date / /
Type	Date / /
Type	Date / /

Date of Last Tetanus: ____/____/____

Tuberculin Test

Date: ____/____/____

Pos	Neg
[]	[]
Results	

Tine	Mantoux
[]	[]
Specify	

If positive, attach physician's statement documenting treatment and follow-up.

Lead Screening
____/____/____
Date
Attach statement of lead screening.

On the basis of my findings as indicated above and on my knowledge of the above named child, I find that: (s)he is free from contagious and communicable disease Yes No, and is able to participate in day camp Yes No.

Name of Family Physician: _____ Signature of Physician: _____

Address: _____ Phone: _____

HEALTH SPECIFICS

Please answer the following questions. For any answer 'YES', please specify condition below in the comment section.

1. Does your child have **known allergies**? ↑ YES ↑ NO
2. Does your child **take medications regularly**? ↑ YES ↑ NO
3. Does your child **have any hearing, visual, or dental condition requiring special attention**? ↑ YES ↑ NO
4. Does your child **have any medical or developmental conditions requiring special attention**? ↑ YES ↑ NO

Comments: _____

AUTHORIZATION
For Medical Treatment of Minors

If your child needs medical, dental, or hospital services, under the law, you as a parent or guardian must give permission. Naturally, if you are with your child you can give permission as the need arises. You can prepare for those unexpected times when you are not with your child by filling out this authorization form. Using this form, you can give permission to other adults to act for you, in your absence, regarding the treatment of your child. This is a legal document. If your child needs unexpected medical treatment, the person(s) authorized below will present this document to the appropriate person, physician, dentist or hospital representative. When a true emergency exists a child may be treated without parental consent. This will happen when a physician determines the child needs immediate medical care and that an attempt to obtain parental or guardian consent would result in a delay which would increase the risk to the child's life or health.

I, being the parent of custody or legal guardian of the above named minor, do hereby appoint: **SILVER BAY YMCA OF THE ADIRONDACKS** to act on my behalf in authorizing unexpected medical, dental, surgical care, and Hospitalization for the above named minor in my absence.

Parent's or Guardian's Signature _____ Date _____

Address: _____ Phone: (H) _____ (W) _____

Medical Insurance Plan: _____ ID or Contract Number: _____

Signature of Witness: _____ Address: _____
(Witness must be different from person authorized to provide care.) This form is valid for a period of one year from date signed.