New England Sports Camps &
Alfond Youth & Community Center

CAMPER HEALTH HISTORY FORM

Mandatory for NESC Campers.

My Camper is Attending (please circle one):

Baseball Camp (ages 8-10) Baseball Camp (ages 8-12) Premier Baseball Camp

Field Hockey Camp Football Camp Softball Camp Swim Camp

Last Name	First Name	DOB	Age at Camp	Gender

Parent/Guardian Name	Parent/Guardian Phone	Parent/Guardian Phone
Parent/Guardian Name	Parent/Guardian Phone	Parent/Guardian Phone
Emergency Contact Name	Emergency Contact Phone	Emergency Contact Phone
Mailing Address	City	State / Zip Code
Email Address	Email Address	

Please list any **ALLERGIES** that our staff should be aware of (medication, food, insects).

Please list any **DIETARY RESTRICTIONS** that your child may have (vegetarian, vegan, gluten free, etc.).

Physical **RESTRICTIONS** (please familiarize yourself with the activities that will take place at camp):

_____ My child has **no** physical restrictions for camp activities.

_____ My child has physical restrictions for camp activities. Please describe below:

Medical Insurance Information

Insurance Company _____ Policy Number _____

Subscriber Name _____

Health Care Providers

Primary Doctor _____ Phone _____

Dentist _____ Phone _____

Orthodontist _____ Phone _____

Boys & Girls Clubs and YMCA of Greater Waterville at the Alfond Youth & Community Center
126 North Street, Waterville, Maine 04901 P: 207-873-0684 F: 207-861-8016
clubaycc.org facebook.com/clubaycc instagram.com/clubaycc

Camp Tracy & New England Sports Camps
(Physical Address) 302 McGrath Pond Road, Oakland, Maine
camptracy.org newenglandsportscamps.org
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Camper Name _____ **DOB** _____

MEDICATION

_____ This camper will **NOT** take any daily medications while at camp. _____ This camper will take daily medications while at camp (list below).

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. Please review camp instructions about required packaging/containers. The AYCC and New England Sports Camps require original pharmacy containers with the camper's name and medication instructions. Medication should be provided only the in the amounts sufficient to last through the entirety of camp.

Name of Medication	Date Started?	Reason for taking the med	What time of day? (breakfast, lunch, dinner,	Amount/dose to give.	How the med is given? (orally, injection, etc.)

These non-prescription medications listed below may be available to your child, under the discretion of the on-site Emergency Medical Technician (EMT) or dedicated staff supervisor in charge of dispensing medications. These over-the-counter medications will be used on an as-needed basis to manage illness and injury. **Please cross out any that staff does not have permission to administer your camper.**

Acetaminophen (Tylenol)

Aloe

Antibiotic cream (topical)

Antihistamine / allergy medication

Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

Sore throat spray

Hydrocortisone cream

Ibuprofen (Advil or Motrin)

Laxatives for constipation (Ex-Lax)

Calamine Lotion

Diphenhydramine antihistamine/allergy medicine (Benadryl)

Parent/Guardian Authorization for Health Care

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give permission to hospitalize, secure proper treatment form, and order injection, anesthesia or surgery for this child. I understand information on this form will be shared on a "need to know" basis with camp staff. I give permission to photo copy this form. In addition the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the programs' staff about my child's health status.

_____ _____ _____

Signature of Parent/Guardian | Date | Relationship to Camper

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Mandatory for NESC Campers.

Camper Name

GENERAL HEALTH HISTORY

	Yes	No		Yes	No
1. Ever been hospitalized?			11. Had fainting or dizziness?		
2. Ever had surgery?			12. Passed out/had chest pain during exercise?		
3. Have recurrent/chronic illness?			13. Had mononucleosis ("mono") during the past year?		
4. Had a recent infectious disease?			14. If female, have problems with periods/ menstruation?		
5. Had a recent injury?			15. Have problems with falling asleep/sleepwalking?		
6. Had asthma/wheezing/shortness of breath?			16. Ever had back/joint problems?		
7. Have diabetes?			17. Have a history of bedwetting?		
8. Had seizures?			18. Have problems with diarrhea/constipation?		
9. Had headaches?			19. Have any skin problems?		
10. Wear glasses, contacts or protective eyewear?			20. Traveled outside the country in the past 9 months.		

If you answered **YES** to any of the above questions, please provide further details below. For travel outside the country, please name the countries visited and the dates of travel.

Mental, Emotional & Social Health (please answer yes or no for each statement)

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?
3. During the past 12 months, seen a professional to address mental/emotional health concerns?
4. Had a significant life event that continues to affect the camper's life? (history of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain YES answers in the space below, noting the number of the question. The camp may contact you for additional information.

Parent/Guardian Authorization for Healthcare

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or the examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Parent/Guardian _____ Date _____

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Camper Name _____ **DOB** _____

Immunization History Provide the month and year for immunizations. Starred (*) immunizations must be current. **Copies of immunization forms from health-care providers or state or local government are acceptable, please attach to this form.**

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis* (DTaP) or (TdaP)						
Tetanus booster * (dT) or (TDaP)						
Mumps, measles, rubella * (MMR)						
Polio * (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCB)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) _____ Had chicken pox _____ Date						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date	Negative	Positive

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

_____ _____ _____

Signature of Parent/Guardian Date Relationship to Camper

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CAMPER HEALTH HISTORY FORM

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Camper Name _____ **DOB** _____

THIS PAGE IS TO BE COMPLETED BY A PHYSICIAN

Copies of a recent sports/camp physical form from health-care providers are accepted in place of this page.

Physical Exam Completed Today: _____ Yes ____ No (If no, date of last physical ____/____/____/)

Weight _____ lbs Height _____ ft _____ in Blood Pressure _____/_____

Allergies _____ no known allergies

If the child has allergies, please select from the options below, list the specifics and describe the reactions:

____ Food Allergies

____ Medicine

____ The environment (insect stings, hay fever, etc.)

____ Other

Diet & Nutrition _____ This camper eats a regular diet
_____ has a medically prescribed meal plan or dietary restrictions (describe below):

This camper is undergoing treatment at this time for the following conditions (describe below):
____ OR None

Medication _____ no daily medications _____ Will take the following medication(s) while at camp
(please list name, dose, frequency - describe below)

Other treatments/therapies to be continued at camp (describe below): _____ none needed

Do you feel the camper will require limitations or restrictions to activity while at camp? ____ no ____ yes
If you answered "Yes" to the question above, what do you recommend? (describe below-attach additional information if needed.)

I have discussed the camp program with the camper's parent/guardian . It is in my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

Name of Licensed Provider (please print) _____ **Signature** _____

Office Address _____ **City** _____ **State** _____ **Zip Code** _____

Phone Number _____ **Date** _____