HEALTH CERTIFICATE

Counselor/Assistant Counselor Name: _____

The activities in which you will participate while at Camp RYLA are generally comparable to those experienced in high school, including physical education activities. Some activities may be very strenuous and the heat is always a factor. The camp supervisors MUST know of any physical limitations, medications or recent medical treatments or surgeries that may affect your welfare. While this will not limit your participation, special precautions can be taken to ensure your safety.

Please check all items listed below with Yes or No. If Yes, please give a brief description of the problem:

YES	NO	
○	○	FREQUENT OR SEVERE HEADACHES
○	○	DIZZINESS OR FAINTING SPELLS
○	○	UNCONSCIOUSNESS FOR ANY REASON
○	○	EYE TROUBLE (*not correctable with glasses*)
○	○	HEART TROUBLE
○	○	HIGH OR LOW BLOOD PRESSURE
○	○	CRONIC OR RECENT EAR TROUBLE
○	○	SIGNIFICANT ABDOMINAL TROUBLE (*including hernia*) UNLESS CORRECTED
○	○	EPILEPSY
○	○	HEAD INJURY
○	○	NERVOUS TROUBLE OF ANY SORT
○	○	ASTHMA OR ANY BREATHING DISORDER
○	○	INJURIES (*requiring hospitalization*) OR SURGERY WITHIN THE LAST 5 YEARS
○	○	ANY ALLERGIES (*including allergies to medications*)
○	○	DIABETES OR HYPOGLYCEMIA
○	○	CURRENT MEDICATIONS (*please list below*)
○	○	OTHER (*please specify any medical conditions not listed above*)

IF YES ON ANY OF THE ABOVE PLEASE DESCRIBE HERE:

I hereby certify that to the best of my knowledge and belief my health is as shown above.

_____ _____

Signature Date