RYLA STUDENT HEALTH FORM

Please fill out completely & print legibly upon selection as a RYLA delegate or alternate.

Name:_____ Sex: M F Age:_____
Last First MI

Date of Birth:_____/_____/_____

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Mother/Guardian #1:_____ Home Phone #:(_____)_____

Home Address:_____
Number & Street City State Zip

Work Phone #: (_____)_____ Cell Phone #: (_____)_____

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Father/Guardian #1:_____ Home Phone #:(_____)_____

Home Address:_____
Number & Street City State Zip

Work Phone #: (_____)_____ Cell Phone #: (_____)_____

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In neither parent/guardian listed above are available in an emergency, please notify:

Alternate Contact #1:_____ Home Phone #:(_____)_____

Work Phone #: (_____)_____ Cell Phone #: (_____)_____

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Name of Family Physican:_____ Phone #:(_____)_____

Name of Dentist/Orthodontist:_____ Phone #:(_____)_____

Do you have family medical/hospital insurance? Y N If yes, Policy Holder's Name:_____

Carrier: _____ Policy or Group #:_____

Do you have family prescription drug insurance? Y N If yes, Policy Holder's Name:_____

Carrier: _____ Policy or Group #:_____

IMPORTANT – MUST BE COMPLETED FOR ATTENDANCE

Parent's Authorization: *This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities, except as noted by the examining physician and/or I. I understand there is some inherent risk in activities at camp and sometimes accidents occur. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I hereby give permission to the physician selected by the camp director to order x-rays, routine tests, and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above.*

I give permission for Rotary and YMCA Camp Tecumseh to use photos or videos of my child in promotional literature.

Parent/Guardian Signature:_____Date:_____/_____/_____

Witness Signature:_____

Continued on back . . .

Last Name:

First Name:

Participant Medical History

(to be completed by parent)

Health History:
(check – giving appropriate dates)

_____ Frequent ear infections
_____ Heart Defect/Disease
_____ Convulsions
_____ Diabetes (onset)
_____ Bleeding/Clotting Disorders
_____ Epilepsy (onset)
_____ Tonsillitis

Allergies

_____ Hay Fever
_____ Poison Ivy, etc.
_____ Insect Stings
_____ Penicillin
_____ Other Drugs
_____ Peanuts
_____ Other Foods

Diseases

_____ Rheumatic Fever
_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps
_____ Asthma
_____ Strep Throat
_____ Mononucleosis

Other diseases or details of the above:_____

_____

Operations or serious injuries (dates): _____

_____

Chronic/recurring illness or special needs:_____

_____

Immunizations are up-to-date: ☐ Yes ☐ No ****REQUIRED**** Date of last Tetanus vaccine:_____

Current Medications *(please list name, dosage, & time schedule)*:_____

_____

_____

_____

Are there any over-the-counter, non-prescription medications or ointments that *SHOULD NOT* be given to your child?
(i.e. Tylenol, bug repellent, Sudafed, etc.)

_____

Last Name: _____ **First Name:** _____