BECKET-CHIMNEY CORNERS YMCA STAFF HEALTH FORM
BCC YMCA---413-623-8991

Staff:____ Date of Birth:_______________
Last Name First Middle (month/day/year)

Home Address:____ Home Phone:(____)________________

If parents are separated, who has legal custody (if applicable)?______________________________

Parent or Guardian_____________________________ Second Parent or Guardian_____________________________

Home Phone_____________________________ Home Phone_____________________________

Cell Phone_____________________________ Cell Phone_____________________________

Business Phone_____________________________ Business Phone_____________________________

Email_____________________________ **Email**_____________________________

EMERGENCY INFORMATION: If Guardian(s) unavailable, contact in this order:

Full Name	Home Phone	Business/Cell Phone	Relationship to Camper
(1)			
(2)			
(3)			

History: (Note chronic illness, chicken pox, fractures, menstrual problems, serious allergies, etc.)

Staff 18 or older:
I hereby authorize the medical designates of the camp to administer any urgent or emergency treatment considered necessary by the camper physician or his/her assistants.

Date:____________________ **Staff Signature** ________________________________

Staff under 18:
On behalf of my child, ________________________, I hereby authorize the medical designates of the camp to administer any urgent or emergency treatment considered necessary by the camper physician or his/her assistants.

Date:____________________ **Parent Signature** ________________________________

Health Insurance Co._____________________________ Phone Number_____________________________

Policy Number_____________________________ Policy is in whose name:_____________________________

Please check before returning: In accordance with State law and ACA standards, the signatures of the physician and the insurance and medical information (including immunizations) must be completed before a camper can be admitted into camp.

Full physical exam must be within two years of the arrival to camp.

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PRE-CAMP PHYSICAL EXAMINATION BY PHYSICIAN

Staff Name:____ DOB____/____/______ Date of Exam ____/_____/_______

WT:___________ HT:__________

Pertinent Medical/Psychological Hx:

ALLERGIES:

Any/all medications to be administered at Camp (include dose and intervals): ______________________________
____
____

Immunization Dates:

DTP/DtaP _________ **OPV/IPV** __________ **Last Td Booster** _______

MMR _________ **MMRB/Measles booster**__________

Hepatitis B __________ __________ __________ **Other Immunizations** __________ __________ __________

HEENT:

Chest/Heart:

Skin:

Neuro:

Genitalia:

Extremities:

Abdomen:

Menarche:

This patient is now fully immunized for Diphtheria, Tetanus, ,Pertussis, Polio, Measles, Mumps Rubella, Hepatitis B, has no evidence of TB, and may participate in any and all physical and athletic activities without restriction.

Physician's Signature____**Date Signed**_________________________________

Address____**Phone**_____________________________________

Email ____@__________________________________