PLEASE RETURN ALL FORMS 2 WEEKS PRIOR TO YOUR CAMPER'S ARRIVAL
A FEE OF $35 WILL BE ASSESSED FOR LATE FORMS!

HEALTH INFORMATION FORM

CAMP COSBY

A Tradition of Excellence Since 1922

Phone: 1-800-85-COSBY • Fax: (256)268-2003 • Email: Info@campcosby.org

Camper Name______________________________ D.O. B.____/_____/_____ Age at Camp______ Sex______
Last First M.I.

Parent/Guardian Name______________________________ Daytime Phone __(_____)____________

Home Address ______________________________ Night-Time Phone __(_____)____________
Street City,State Zip

EMERGENCY CONTACT

If, in the event of an emergency, the parent/guardian cannot be contacted, please contact the following:

Name ____________________ Relationship____________ Daytime Phone __(_____)____________

Address ______________________________ Night-Time Phone __(_____)____________
Street City,State Zip

Name ____________________ Relationship____________ Daytime Phone __(_____)____________

Address ______________________________ Night-Time Phone __(_____)____________
Street City,State Zip

HEALTH HISTORY

Please review the following list of medical issues and fill in where applicable:

Yes	No	Allergies	Yes	No	Illnesses, Etc.	Yes	No	Chronic Illness
____	____	Insect Stings	____	____	Ear Infection	____	____	Chicken Pox
____	____	Poison Ivy/Oak	____	____	Asthma	____	____	Measles
____	____	Penicillin	____	____	Rheumatic Fever	____	____	German Measles
____	____	Aspirin	____	____	Epilepsy	____	____	Mumps
____	____	Foods	____	____	Diabetes	____	____	Hepatitis A
____	____	Other Drugs	____	____	Sleep Walking	____	____	Hepatitis B
			____	____	Bed Wetting	____	____	Bleeding
			____	____	Hyperactivity	____	____	Clotting
			____	____	Behavior Disorder	____	____	Other

For any "yes" above please give the date of the most recent occurrence and details______________________________

____

____

Has the camper had any serious injuries or operations? If so, please list and give dates ______________________________

____

____

Is there any additional pertinent medical information Camp Cosby staff should know about?______________________________

____

____

For female campers, has the camper menstruated? ____________________ If so, is her menstrual history normal?____________

If not, has the camper been told about it? ____________________ Special Considerations____________________

Immunization History

(required immunizations must be determined locally–please give most recent date)

_______ DTP Series	_______ Polio Booster	_______ Mumps (live vac.)	_______ Hepatitis B Series
_______ DTP Booster	_______ Tetanus Booster	_______ Typhoid	____________________
_______ Polio OPV (Sabin)	_______ Measles (live vac.)		____________________

YMCA Mission: To put Judeo-Christian principles into practice through programs that build healthy spirit, mind, and body for all.

ALL CAMPERS ARE REQUIRED TO HAVE A PHYSICAL BEFORE ATTENDING CAMP

RECOMMENDATIONS/RESTRICTIONS

Special Diet______________________________

Waterfront Activities (swimming, etc.) ______________________________

____

Strenuous Activities (Alpine Tower, running, etc.)______________________________

____

HEALTH CARE RECOMMENDATIONS

(to be completed by licensed medical personnel)

Height____________________ Weight____________________ Blood Pressure____________________

The above camper is under the care of a physician for______________________________

____

____

____

Treatment to be continued at camp ______________________________

____

Medications to be administered at camp (name, dosage, frequency) ______________________________

____

____

Medically prescribed meal or dietary restrictions ______________________________

____

Known allergies ______________________________

____

I have examined this individual on______________________________. In my professional opinion, this individual...

____Should be allowed to participate in an active camp program at Camp Cosby

____Should NOT be allowed to participate in an active camp program at Camp Cosby

Description of any limitation or restriction placed on this camper's activities______________________________

____

____

Additional information for Camp Cosby Health Care Staff ______________________________

____

____

Printed Name (of licensed medical personnel)______________________________Title____________________

Signature ______________________________ Date____________________ Phone (_______)____________________

Address ______________________________

FOR CAMP USE ONLY

Screening Record

Date Screened ______________________________ Time_________ Updates Noted ____Yes ____No ____N/A

Current Health Needs Identified______________________________

Medications Received ______________________________

____

Observational Notes ______________________________

Screened By______________________________

PARENT/GUARDIAN AUTHORIZATIONS

ASSUMPTION OF RISK AND RELEASE OF LIABILITY

By signing this form, I understand that I am giving permission for my child to participate in Camp Cosby summer camp programs. Furthermore, I understand that certain risks may be involved with participation in Camp Cosby activities (water skiing, mini bikes, kayaking, etc.) and that certain activities may be physically demanding and potentially dangerous. I agree and hereby state that participation in Camp Cosby summer camp activities is strictly voluntary and is the choice of my child and myself. I further state that by signing this form, I agree to assume for my child, myself, my heirs, and executors all risks of physical injury or emotional upset which may be a result of my child's participation in a Camp Cosby summer camp program. In addition, I agree to release from liability YMCA Camp Cosby, its employees, volunteers, agents and affiliates in the event of such result.

By signing this form, I agree that I have had ample opportunity or review and read this entire document (health history included). I agree to this form and it's contents, and to be bound by it's terms. Furthermore, I agree that all information stated in the Health Information Form is correct and complete, to the best of my knowledge.

Camper Name ______________________________ Session/Code ______________________

Camper Signature ______________________________ Date ______________________

Parent/Guardian Printed Name ______________________________

Parent/Guardian Signature ______________________________ Date ______________________

Permission to Treat/Administer Medications

By signing below, I hereby give permission (standing orders) to Camp Cosby and its staff to treat my child for injuries as needed. I understand that all Camp Cosby staff are certified, as a minimum, in First Aid and C.P.R. I understand there is a medical infirmary on the premises with a full time nurse on site. In the unlikely event of an emergency, I give permission (standing orders) to Camp Cosby, it's staff, and local medical personnel to transport my child to a medical facility if necessary (hospital, clinic, etc.). Furthermore, I give permission (standing orders) to Camp Cosby and it's staff to dispense/administer medications brought to camp by parent/guardian for my child or prescribed by the camp's physician while in attendance. Any restrictions or recommendations for medications will be listed below.

Are there any restrictions/recommendations for medications (aspirin, acetaminophen, antihistamines, etc.) ______________________

____

____

____

Parent/Guardian Printed Name ______________________________

Parent/Guardian Signature ______________________________ Date ______________________

Permission To Take Photos Of Your Child

These photos will be included in CampLive, our online photo and messaging service for you to view. Without your signature, your child's photo will not appear on the website and you will not see photos of your child.

During the summer, Camp Cosby's staff may be armed and ready with cameras on the look-out for smiling faces gracing Camp Cosby's programs. In the event that your child is captured by one of our amateur photographers, that image may be used for marketing purposes of Camp Cosby. Please sign below if you agree to our use of your child's photograph.

Parent/Guardian Signature ______________________________ Date ______________________

INSURANCE INFORMATION

Is the camper covered by medical/hospital insurance? ______________ **If so, list policy/group number** ______________

Carrier Name ______________________ Carrier Address ______________________

Name of Insured ______________________ Relationship to Camper ______________________

Parent/Guardian Signature ______________________ Date ______________________

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2 WEEKS PRIOR TO YOUR CHILD'S ARRIVAL
FAX: 256-268-2003 OR MAIL TO YMCA CAMP COSBY 2290 PAUL BRYANT RD. ALPINE, AL. 35014