2008 MDI YMCA
Camp/Childcare Health Record

Child's Name:_____

Birthdate:_____ Date of Last Tetanus Shot:_____

Important: Please notify the Child Care Director if child is exposed to any communicable diseases during the 3 weeks prior to attendance.

Operations or Serious Injuries (include dates):_____

_____

Chronic or Recurring Illness or Medical Condition, including Allergies:_____

_____

Dietrary or Nutritional Restrictions/Concerns:_____

_____

Mental/Emotional/Behavioral Issues:_____

_____

*Current Medications:_____

_____

**If it is necessary for MDI YMCA staff to dispense medication during program hours, medication must be given to the Childcare Director in the original container. Medication should be clearly labeled with proper dosage and time, and the child's and physician's names. Staff cannot give injections or advanced medical care for medical conditions.*

Can Child Take Part in All Program Activities?_____

_____

Child's Dentist/Orthodontist:_____Tel#:_____

Child's Physician:_____Tel#:_____

Medical Insurance Carrier:_____

Insurance Group #:_____Insurance Policy #:_____

Check all that apply.
Give approximate dates

Health History

Frequent Ear Infections: _____
Heart Defect/Disease: _____
Convulsions: _____
Diabetes: _____
Bleeding/Clotting Disorders: _____
Hypertension: _____
Mononucleosis: _____
Asthma: _____
Other: _____

Diseases

Chicken Pox: _____
Measles: _____
German Measles: _____
Mumps: _____
Other: _____

Allergies

Food: _____
Hay Fever: _____
Ivy Poisoning, etc.: _____
Insect Stings: _____
Penicillin: _____
Other (Specify): _____

Attach a copy of current vaccination record!

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Parent/Legal Guardian's Authorization

This health history is correct so far as I know, and the person herein described has permission to engage in all program activities except as noted. I hereby give permission to the physician selected by the Child Care Director to order x-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Child Care Director to hospitalize, secure proper treatment for and to order injection, anesthesia and/or surgery for my child as named above. I accept responsibility for medical/surgical treatment charges that may be incurred on my child's behalf.

_____

Signature of Parent/Legal Guardian *Date*