



FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

CAMP HUFF 'N PUFF

2018 Camp Registration and Medical Form

Camper's Name: _____ Age: _____ Date of Birth: _____

Gender: Male/Female Grade Entering: _____ Insurance Company: _____

Address: _____ City: _____ State _____ Zip: _____

Parent 1: _____ City: _____ State _____ Zip: _____

Home #: _____ Mobile #: _____ Work #: _____

Parent 1 Email: _____

Parent 2: _____ City: _____ State _____ Zip: _____

Home #: _____ Mobile #: _____ Work #: _____

Parent 2 Email: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

The total cost of Asthma camp is \$125. A non-refundable deposit of \$50 must accompany this registration. The balance of payment is due at least one week prior to the beginning of camp.

Registrations are also accepted on-line at helenaymca.org/camp-child

Our purpose is to provide the best quality programs for the most affordable price, based on adequate enrollment. Therefore, NO REFUNDS will be granted once the program has started. Please be sure your child is ready for participation in the activity before enrolling. A credit (minus a 25% administrative charge) may be arranged for future programs. Deposits are not refunded or credited. All requests must be in writing. Medical reasons for withdrawal will be reviewed on an individual basis.

I understand that there are risks of injury while participating in camp activities including, but are not limited to; death, serious neck and spinal injuries which may result in complete or partial paralysis, injury to internal organs, bones, joints, ligaments, muscles, tendons and other aspects of muscular skeletal system and serious injury or impairment to other aspects of the body and general health and well being. The YMCA will do its best to minimize these risks. I understand that the YMCA does not carry health insurance covering illness or injury for the participants in the program and I have included the name of my insurance company on the application. I hereby authorize the staff or volunteers of the YMCA to use their best judgment to obtain treatment for my child in any emergency and agree to any required services and the payment of the same.

PLEASE INITIAL FOR YOUR CONSENT:

_____ Photos/video taken of my child to be used by the YMCA for promotional and publicity purposes.

_____ Swimming

_____ Zip Line, Challenge Course, Climbing Wall

_____ Non-Emergency Medical Care

_____ Administration of non-prescribed medication

_____ Administration of prescribed medication

By affixing my signature, I have read and understand the participation and payment policy.

Parent/Guardian Signature: _____ Date: _____



CAMP HUFF 'N PUFF 2018 MEDICAL FORM

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Year or age of diagnosis of asthma? _____
 Number of emergency room visits or hospitalizations for asthma? _____ Last year? _____
 Number of times oral steroids taken in past year for asthma? _____
 Estimate of asthma severity: Mild _____ Moderate _____ Severe _____
Medication Allergies: list and describe: _____
Food Allergies: list and describe _____
 Immunizations current? _____ Date of last tetanus vaccine? _____
 Physician: name, address, phone number _____

Other Medical Conditions:

Seizures	Yes (___) No (___)	Recent Infections	Yes (___) No (___)
Heart Disease	Yes (___) No (___)	Bleeding Disorders	Yes (___) No (___)
Diabetes	Yes (___) No (___)	Bed Wetting	Yes (___) No (___)
Gastrointestinal Disorders	Yes (___) No (___)	Allergies	Yes (___) No (___)
Psychiatric Disorders	Yes (___) No (___)	Other	_____

List all medications taken on a daily or as needed basis:

MEDICATION	DOSAGE	TIME GIVEN	REASON

****Hyposensitization injections (immunotherapy) will not be administered during Camp, please make other arrangements.**

**For medical questions about this form or camp please contact medical director, Tom Strizich, MD at 447-2885 or 439-9493.

Parent's Authorization: The health history is accurate and correct, to my knowledge. The child herein described has my permission to engage in all prescribed camp activities except as noted by me and/or our physician. I hereby give permission to the camp physician to order x-rays, routine tests, and treatment for the health of my child, in the event I cannot be reached in an emergency. I hereby give permission to the camp physician to hospitalize, secure proper treatment for, and to order injections and/or anesthesia and/or surgery for my child, in the event I cannot be reached in an emergency.

Parent/Guardian Signature: _____ Date: _____

**RETURN THIS ENTIRE FORM WITH PAYMENT PAYABLE TO:
HELENA FAMILY YMCA, 1200 N. LAST CHANCE GULCH, HELENA, MT 59601**