

CAMP WOOD YMCA
Camper Letter to Counselor

This letter to your cabin counselor will help him/her get ready for your arrival at camp. The information you provide will help your counselor get to know you better. Your counselor will also use some of the information to help them plan afternoon activities for you and your cabin mates.

My full name is _____ but my friends just call me _____.
The things I like to do most with my friends are _____

_____.
What I like most about school is _____
and what I like least about school is _____.
My hobbies are _____.
My favorite type of music is _____.
The sports or activity that I enjoy the most are _____.
Most of my friends would probably describe me as someone who is _____

_____.
If you were to ask my best friend about me, they would say that I _____

_____.
The qualities I like most in people are _____.
My best friends are people who _____.
I'm coming to Camp Wood YMCA because _____

_____.
The kind of counselor that I would like to have most is one that _____

_____.
As my counselors, I also want you to know that _____

_____.
When I get to Camp Wood, the things I want to do most are _____

_____.
Some of the things I don't like to do are _____.

Circle one of the following: (I have) or (have not) been to camp before. The camp name and year that I attended was _____.

Camp Wood Agreement

"I agree to abide by the rules established by all campers and to use behavior appropriate to Camp Wood YMCA. I agree to try new activities and to become a part of my cabin group.
I agree not to use bad language, drugs, tobacco, or alcohol in any form while in camp or on a cap trip.
I also agree to respect fellow campers and the camp's natural environment."

Camper signature: _____ Date: _____.

Parent Letter to Counselor

Parents, this letter is to help your child's counselor understand what you hope your child gains from their Camp Wood YMCA experience.

The kind of counselor I want for my child is one that _____

I hope my child gain this from their Camp Wood experience _____

How would you describe your son our daughter? Please include anything that would help us understand him/her. Have there been any recent changes in their life (a move, death, separation, birth of sibling?)

How does your child get along with children their own age? _____

Does your child have any problems that affect his/her behavior (ADD, ADHD, ODD, etc)? If so, what is the best way to manage these behaviors? What works and what doesn't? _____

With your child, what is the best method of discipline to use if necessary? _____

If your child expresses interest in extending their stay at Camp Wood YMCA may we contact you to explore this possibility? Please circle one YES No

For Former Campers Only

If you have been a camper at Camp Wood YMCA before, please complete the information below.

While at camp during the previous summer(s), the things which helped me grow the most were:

I have decided to return to camp because: _____

How did your camp experience help you during the school year? _____

What concerns do you have about returning to camp this summer? _____

What was the best part about your last summer at camp? _____

If you could change anything about camp, what would it be? _____

Camp Wood YMCA Health History Form for Summer Residence Camp

Please fill out completely and returned three weeks prior to your child attending camp.
Mail to: Camp Wood YMCA 1101 Camp Wood Rd. Elmdale, KS 66850

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. History form (first three pages) must be filled out by parents/guardians of minors or by adults themselves. Update is required annually. An approved licensed medical personnel must sign the last page at least every two years.

Camper name _____ Birth date _____ Age at Camp _____ Sex: _____
Last First Middle

Home address _____
Street Address City State Zip

Custodial parent/guardian _____ Phone _____

Home address _____
(if different from above) Street Address City State Zip

Work Phone _____ Cell Phone _____

Second parent/ guardian or emergency contact _____

Home Phone _____ Work Phone _____ Cell Phone _____
Name

If not available in an emergency, notify _____

Relationship _____ Phone _____

Name of family physician _____ Phone _____

Other than the participants' parents, the following people have my permission to pick up my child from Camp Wood YMCA

1) _____

2) _____

ALLERGIES List all known medication, food or other allergies including insect stings, hay fever, asthma, animal dander, etc. Describe reaction and management of the reaction.

Dietary Restrictions: Please list any dietary restrictions. (not eat red meat, pork, eggs, poultry, seafood, dairy products, wheat or milk allergies, etc.)

Insurance information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name _____ Group # _____

Photocopy of front and back of health insurance card must be attached to this form!

This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting in loco parentis if the person herein named is a minor. Further, it is my intention that the appropriate representative of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representative related to the person's ability to participate in camp activities; and (ii) in case of minors, to provide relevant information to the camp representative to keep me informed of my child's health status.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer _____

Printed Name _____ Date _____

** If for religious reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.*

Form Expires

Session Attending

Name

MEDICATIONS BEING TAKEN Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Med #3 _____ Dosage _____ Specific times taken each day _____

Attach additional pages for more medications
Identify any medications taken during the school year that participant does / may not take during the summer: _____

Is the participant up to date on all immunizations? Yes No Date of last tetanus(DTP/TD) shot: _____

Staff only: TB Mantoux Test Date of last test _____ Result: Positive Negative

Over the Counter Medication Use Please review the following over the counter medications and circle any options listed you **DO NOT** want your child to receive. Camp Wood YMCA typically uses the generic form of the name brand medications listed below.

Sunburn Solarcaine, Aloe Vera gel

Allergies Claritin, Benadryl

Diarrhea Kaopectate, Immodium

Red Irritated Eyes Clear Eyes Visine

Constipation Milk of Magnesia, Dulcolax

Poison Ivy Ivy Rest, Calamine Lotion, Caladryl Lotion, Hydrocortisone Cream

Sore Throat Chloraseptic Spray Lozenges

Headache / General Discomfort / Fever Tylenol (Acetaminophen), Advil (Ibuprofen)

Discomfort from water in ear Swim Ear

Upset Stomach Pepto Bismol, Mylanta or other antacid, Rolaids

Cough/Cold Cough Syrup Nasal Decongestant

Cuts & Abrasions: Hydrogen peroxide, Neosporin

Insect Bites Benadryl Chiggerex Caladryl Lotion

	Yes	No		Yes	No		Yes	No
1. Recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	15. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2. Chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	16. Have an orthodontic appliance being brought to camp? .	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	17. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>	29. Hayfever.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	30. Poison Ivy Allergy.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	31. Insect sting allergy.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	20. Had mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	32. Frequent sore throats.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	21. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>	33. Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	22. sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>	34. Clotting disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	23. If female: (a) have you begun menstruating?	<input type="checkbox"/>	<input type="checkbox"/>	35. Fears/Phobias.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever pass out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	(b) have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>	36. Behavior Problem.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	24. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	37. ADD/ADHD.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	25. bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>	38. Speech problems.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Ever have an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>	39. Hearing problems.....	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>				40. Vision problems.....	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" answers, noting the number of the questions.

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which camp should be aware.

Please list and explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary) _____

Treatment to be continued at camp _____

Doctor's Physical Examination: I have examined the above participant on _____ and in my opinion he/she is / is not able to participate in an active camp program.

I HEREBY CERTIFY THAT I AM QUALIFIED BY TRAINING AND EXPERIENCE TO PROPERLY PERFORM THE EXAMINATION AND MAKE THE EVALUATION REFLECTED ON THIS FORM

Signature of physician _____, MD, PA, or CNP

Name of physician (print / type) _____ Date signed by Dr _____

Address _____ Phone () _____