CAPITAL DISTRICT YMCA
Circle of Champs Medical Form

Attention Medical Professional
Please complete this form and send it to Lisa Wolcott at the Capital District YMCA.

Please mail it to Lisa at 250 Winding Brook Drive, Guilderland NY 12084.
Or, please fax it to Lisa's attention at 518.456.3284.

Medical Diagnosis (please print):

____

Please indicate if the child has a history of the following:

[ ] Anemia	[ ] Diabetes	[ ] High Blood Pressure	
[ ] Appendicitis	[ ] Ear Infections	[ ] Hyperkinesis	[ ] Skin Problems
[ ] Asthma	[ ] Fainting	[ ] Seizures	[ ] Tonsillitis
[ ] Contact Lenses	[ ] Hay Fever	[ ] Severe Headaches	[ ] Swimmer's Ear

If a hepatitis carrier, what type? ____________________________________

Central Line [ ] Yes [ ] No Specifications ______________________________

Attention Parents
My child is fit for and has permission to participate in swimming. [ ] Yes [ ] No

Any special challenges we should know about? ___________________________

Please list all medications (oral, inhalants, injections) that give an allergic reaction.

____

Please also list foods, insects, and any environmental sensitivity, the frequency, and usual treatment for the reaction.

____

Please list all medications (oral, inhalants, injections) the child is bringing to activities.

____

Please list all medications your child is routinely given at home.

____

Please record the most recent dates for your child's immunizations.
Tetanus / / Measles / / Polio / / Rubella / /
DPT / / Mumps / /

To be filled out and signed by a physician

I have examined (child's full name) ________________________ and found her/him to be able to take part in YMCA Circle of Champs programs. I certify that she/he is currently affected by the following life-threatening illness:

Diagnosis: ____

Restrictions/Comments:

____

____

Doctor's Name ________________________________ Signature ______________________

Doctor's Office/Practice ____

Phone ___________________________________

Parent Commitment

I certify that my child may attend YMCA Circle of Champs Programs and is capable of participating in program activities. I understand that summer camp does not carry health and accident insurance and that I am responsible for health-incurred costs.

I grant the YMCA Circle of Champs and its agent's full authority to take whatever action they deem necessary regarding my child's health and safety, and I fully release the Capital District YMCA from any liability in connection to those decisions.

Parent Authorization for Treatment

In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the camp director to hospitalize and secure treatment for my child.

The health history provided here is correct to the best of my knowledge, and my child, who is named above, has my permission to engage in all camp activities except as noted by me on this form and/or my child's physician.

____
Print Parent / Guardian Name

____
Signature

Date