



**CAPITAL DISTRICT YMCA
Circle of Champs Medical Form**

Attention Parents Please complete page 1 of this document prior to your child’s medical professional completing page 2

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.

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 _____

Please record the most recent dates for your child’s immunizations.

Tetanus / / Measles / / Polio / / Rubella / /
DPT / / Mumps / /



Attention Medical Professional Please complete page 2 of this form **Parents,** email or mail to Rusty Decker.
RDecker@CDYMCA.org or 900 Delaware Avenue, Delmar, NY 12054

To be filled out and signed by a physician

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

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Hyperkinesis | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Seizures | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Swimmer's Ear |

If a hepatitis carrier, what type? _____

Central Line Yes No Specifications _____

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 _____