

YMCA Participant Health Record (page 1)

BOTH PAGES MUST BE COMPLETED, SIGNED & SUBMITTED TOGETHER. **DUE FEBRUARY 25, 2011**

Participant's Name: _____ DOB: _____ SEX: _____

Address: _____ Postal Code: _____

Home Phone: _____ School: _____

HEALTH HISTORY (give approximate dates)

Ear Infection _____	Hay Fever _____	Chicken Pox _____
Rheumatic Fever _____	Poison Ivy _____	Measles _____
Convulsion _____	Insect Stings _____	German Measles _____
Diabetes _____	Mumps _____	Asthma _____

PAST ILLNESSES/OPERATIONS: _____

FOOD & OTHER ALLERGIES: _____

CHRONIC OR REOCCURING ILLNESSES: _____

BEHAVIOR ISSUES: _____

ACTIVITIES TO BE ENCOURAGED: _____

ACTIVITIES TO BE RESTRICTED: _____

CURRENT CONDITIONS

MEDICATION TAKEN: _____

APPLIANCES WORN OR NEEDED (EX. GLASSES, BRACES): _____

CONDITIONS WHICH MODIFY ACTIVITY: _____

IMMUNIZATION HISTORY

This is a record of the dates of the basic immunization and most recent booster doses

	DATE	DATE	DATE
DPaT or DTP or TD or Td			
Polio			
MMR			
Hepatitis B			
Varicella			
Pneumococcal Conjugate (PCV)			
TB/PPD Screen			
OPV / IPV			
PPD / Mantoux			
Other			

PARENT/GUARDIAN CONSENT FOR EMERGENCY MEDIAL TREATMENT

I do hereby give authority to the YMCA to obtain necessary emergency medical treatment for me, or if under 18 for my child with the understanding that the family physician will be notified as soon as possible.

Relationship to Teen: _____ Signature: _____ Date: _____



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YMCA Participant Examination Form (page 2)

This form must be completed by the participant's Medical Provider.

It is acceptable to submit a similar form from your Doctor's office or school – but the examination must occur within 6 months of travel and contain all information requested in this document.

DATE OF EXAM: _____ FACILITY NAME: _____

ADDRESS: _____ POSTAL CODE: _____

TELEPHONE: _____ COMPLETED BY: _____

Codes for using this form: **S = Satisfactory, X= Not Satisfactory (explain), O= Not Examined**

GENERAL APPEARANCE: _____

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____

URINANALYSIS _____ HGB. TEST _____ POSTURE/SPINE _____

EYES _____ VISIONS _____ GLASSES _____

EARS _____ HEARING _____ THROAT/TONSILS _____

HEART _____ LUNGS _____ EXTREMITIES _____

FEET _____ SKIN _____ NOSE _____

TEETH _____ ABDOMEN _____ HERNIA _____

ALLERGIES _____

NEUROLOGICAL FINDINGS _____

RECOMMENDATIONS AND RESTRICTIONS DURING PROGRAM

SPECIAL DIET _____

SPECIAL MEDICINE _____

SWIMMING _____

STRENUOUS ACTIVITY _____

OTHER NOTES _____

I have examined the individual mentioned, reviewed his/her health history and it is my opinion that he/she is physically able to work in a YMCA program interacting with youth and teenagers, after school and other Youth Center activities, except as noted above.

Examining Physicians Signature: _____ Date: _____

Hospital: _____ Phone: _____



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