

PHYSICIAN'S CARE FORM

OUR MISSION: The YMCA of San Diego County is dedicated to improving the quality of human life and to helping all people realize their fullest potential as children of God through the development of the spirit, mind and body.



**FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY**

This section to be completed if currently under a doctor's care or *asterisk-health condition is checked on previous form.

A doctor's written authorization is only required if the camper has a history of asthma, heart defect/disease, seizures, diabetes, has been recently hospitalized, or is currently under a doctor's care. If so, complete this section.

HEALTH EXAMINATION BY LICENSED PHYSICIAN

Child's Name		birth (mm/dd/yyyy)		Sex
Parent's Name				
Because of this camper's medical history, we have asked that your written authorization be provided prior to their attendance at YMCA Camp. Please realize that camp is held at either mountain (4300 feet elevation) or oceanfront settings. The programs are very active with strenuous hiking, games, swimming, surfing, and camp activities. Your careful consideration is appreciated.				
<input type="checkbox"/> I have examined the child named on this form within the past two years.			Date of Exam (mm/dd/yyyy)	
<input type="checkbox"/> After examination and my review of his/her health history, it is my opinion that this person is physically able to engage in camp activities, except as noted below.				
Height	Weight	Blood Pressure		
Is the applicant under the care of a physician for any conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please explain:				
Any specific activities to be encouraged or limited by physician's advice?				
Any medically prescribed meal plan or dietary restrictions?				
Any treatment or medications to be continued at camp (please give specific dosages)?				
Any allergies? (Food, drugs, plants, insects, etc)				
Additional health information:				
PHYSICIAN INFORMATION				
Address			Phone	
City	State	Zip	Email	
Date Form Completed (mm/dd/yyyy)		Completed by:		
SIGNATURE				
Physician Signature			Date	

YMCA OVERNIGHT CAMPS - MARSTON | SURF | RAINTREE

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