# YMCA OF ORANGE COUNTY - CAMP OAKES REGISTRATION

Please return completed packet no later than June 1, 2023

## SESSION: Camp Oakes - July 16th - 23rd, 2022

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Age Group | | ☐ Camper (ages 8-14) | | | | | |
| | | ☐ Counselor-In-Training "CIT" (ages 15-17) | | | | | |
| T-Shirt Size | ☐ Child Size | ☐ Adult Size | ☐ S | ☐ M | ☐ L | ☐ XL | ☐ XXL |

## CHILD INFORMATION

| Child's Last Name | Child's First Name | Date of Birth | Gender | Phone # |
|---|---|---|---|---|
| | | | ☐ M ☐ F ☐ Non-Binary | |
| **Home Address** | | **City** | **State** | **Zip Code** |
| | | | | |
| **Mailing Address** (if different from Home Address) | | **City** | **State** | **Zip Code** |
| | | | | |

## PARENT / GUARDIAN INFORMATION

RESPONSIBLE PARTY INFORMATION - The "Responsible Party" is the parent or legal guardian enrolling the child and primarily responsible for payment fees, signing releases, authorizing individuals to sign in/out the child.

| Responsible Party's Last Name | Responsible Party's First Name | Date of Birth | Relationship to Child | Home Phone # |
|---|---|---|---|---|
| | | | | |
| **Email Address** | | | **Cell Phone #** | |
| | | | | |
| **Home Address** ☐ Check if same as child | | **City** | **State** | **Zip Code** |
| | | | | |
| **Occupation** | **Company** | **City** | **Work Phone #** | |
| | | | | |
| **Other Parent/ Guardian Last Name** | **Other Parent/ Guardian First Name** | **Date of Birth** | **Relationship to Child** | **Home Phone #** |
| | | | | |
| **Email Address** | | | **Cell Phone #** | |
| | | | | |
| **Home Address** Check if same as child | | **City** | **State** | **Zip Code** |
| | | | | |
| **Occupation** | **Company** | **City** | **Work Phone #** | |
| | | | | |

## FOSTER / AGENCY INFORMATION (if applicable)

| Foster/Other Agency Name | Foster/Other Agency Contact Person | Foster/Other Agency Phone # | Foster/Other Agency Email | CFS Region |
|---|---|---|---|---|
| | | | | |

## CABIN-MATE REQUEST*

| Requested Cabin-mate Name: | | Requested Cabin-mate Age: | |
|---|---|---|---|

*The YMCA will make every attempt to honor one cabin-mate request per camper for children of similar age and gender.



Camper Name_____

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## EMERGENCY CONTACTS

EMERGENCY CONTACTS - The following individuals have my **unrestricted** permission to sign my child out from the program and can be contacted in an emergency if/when I cannot be reached.

**MINIMUM OF TWO REQUIRED IN ADDITION TO PARENTS/GUARDIANS (on page 1).**

| **Emergency Contact #1** | | Relationship to Child |
|---|---|---|
| | | |
| Cell Phone # | Home/Work Phone # | Email Address |
| | | |
| **Emergency Contact #2** | | Relationship to Child |
| | | |
| Cell Phone # | Home/Work Phone # | Email Address |
| | | |
| Emergency Contact #3 | | Relationship to Child |
| | | |
| Cell Phone # | Home/Work Phone # | Email Address |
| | | |
| Emergency Contact #4 | | Relationship to Child |
| | | |
| Cell Phone # | Home/Work Phone # | Email Address |
| | | |
| Emergency Contact #5 | | Relationship to Child |
| | | |
| Cell Phone # | Home/Work Phone # | Email Address |
| | | |

## RESTRICTED PICK-UP

RESTRICTED PICK-UP - The following individuals are **restricted** from signing my child out from the program due to a court-issued restraining order. **A certified copy of the official court documentation must be kept in child's file.**

| | | | |
|---|---|---|---|
| Name: | | Date of Court Order: | |
| Name: | | Date of Court Order: | |



Camper Name_____

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## CHILD QUESTIONAIRE

CHILD QUESTIONAIRE - Please answer the questions below thoroughly and honestly. This information will be shared with your child's counselor to help facilitate the best possible camp experience.

| |
|---|
| What does your child prefer to be called? |
| Who else lives at home? |
| Has your child been to a resident (overnight) camp before? If so, when and where? |
| Does your child get along easily with friends? |
| Does your child ever wet the bed? |
| If yes, what methods have you found effective in preventing it? |
| Does your child ever sleepwalk? |
| If yes, what methods have you found effective in preventing it? |
| Does your child have nightmares? |
| If yes, what methods have you found effective in preventing it? |
| Has your child ever run away from home? |
| How does your child feel about going to camp? |
| How does your child spend his/her free time? |
| What skills do you hope your child might get out of camp? |
| Does your child have friends or siblings coming to the same camp? |
| Please provide any information that will assist counselors in ensuring that your child will have a positive experience at camp. |



Camper Name_____

# YMCA OF ORANGE COUNTY - CAMP OAKES REGISTRATION

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## RELEASE FOR ADMINISTRATION OF MEDICATION

Prescription & Non-Prescription

| CHILD'S NAME | PARENT/GUARDIAN'S NAME | PARENT/GUARDIAN'S PHONE # |
|---|---|---|
| | | |

The law allows certain persons to assist in carrying out a physician's recommendation. It is understood that the YMCA Program is not legally obligated to administer medication to my child or ward. Therefore, I agree to hold the YMCA Program, its personnel and employees free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them.

**All medication MUST be in the original container and labeled with the child's name and dispensing instructions. Medication will be dispensed as labeled on the container, no modifications will be accepted.**

Please list all medications (including over-the-counter, prescription and non-prescription drugs) that the participant is ROUTINELY taking. Please provide enough medication to last the entire duration of the camp session.

Please be as specific as possible to ensure proper administration of medications. Use other side for further explanation. Use aditional pages if more than four medications are needed.

Medication: ☐ This camper will not take any daily medications while attending camp.
☐ This camper will take the following daily medication(s) while at camp.

Medication is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies.

| Name of Medication | Date Started | Reason for Taking | Time of Day Given | Amount or Dose | How It Is Given |
|---|---|---|---|---|---|
| | | | ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:_____ | | |
| | | | ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:_____ | | |
| | | | ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:_____ | | |
| | | | ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other:_____ | | |

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. *Cross out those the camper should not be given.*

Diphenhydramine (Benadryl)
Calamine lotion
Topical antibiotic cream
Aloe/Sunscreen
Generic cough drops
Hydrocortisone 1% cream
Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Antihistamine/allergy medicine
Chlorpheneramine maleate
Laxatives for constipation (Ex-Lax)
Chloraseptic (Sore throat spray)
Pseudoephedrine (Sudafed)
Phenylephrine (Sudafed PE)
Guaifenesin (Robitussin) Dextromethorphan (Robitussin DM)
Lice shampoo or scabies cream (Nix, Elimite)
Bismuth subsalicylate (Pepto-Bismol)

Parent/Guardian Signature | Parent/Guardian Name | Date



Camper Name_____

# CAMPER HEALTH HISTORY FORM

*Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

american CAMP association®

***Return this completed packet by email to the Andie Prabhu no later than June 1st, 2023.***

***aprabhu@ymcaoc.org***

***If you have any questions, call or email Andie Prabhu at 714.508.7671***

Dates will attend camp: from _____ to _____
Month/Day/Year Month/Day/Year

Camper Name: _____
First Middle Last

☐ Male ☐ Female Birth Date _____ Age on arrival at camp: _____
Month/Day/Year

***To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.***

1) ***Complete pages 5, 6 and 7 (CAMPER HEALTH HISTORY FORM) of this form and make a copy.***
2) ***Send the original, signed to camp by the requested by date.***
3) ***Complete the top of page 8 (PHYSICIAN PHYSICAL FORM) and provide the copy of CAMPER HEALTH HISTORY FORM with page 8 to your child's health-care provider for review and completion.***
4) ***After it has been completed and signed by your child's health-care provider, return page 8 (PHYSICIAN PHYSICAL FORM) to camp by the requested by date.***

Camper Home Address: _____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____(_____)_____

Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name:_____ Relationship to Camper: _____ Preferred Phones: (_____) _____(_____)_____

Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____(_____)_____

**Allergies:** ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
***(Please describe below what the camper is allergic to and the reaction seen.)***

**Diet, Nutrition:** ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet. ☐ This camper is lactose intolerant. ☐ This camper is gluten intolerant. ☐ Other, ***please explain in space.***

**Restrictions:**

☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations.
***(Please describe below.)***

**Medical Insurance Information:**

This camper is covered by family medical/hospital insurance ☐ Yes ☐ No

***Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.***

Insurance Company_____ Policy Number_____

Subscriber_____ InsuranceCompany Phone Number (_____)_____

**Parent/Guardian Authorization for Health Care:**

**This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.**

Signature of Custodial Parent/Guardian _____ Date: _____ Relationship to Camper: _____

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

Camper Name _____ _____ _____
First Middle Last

(For Camp Use) Cabin or Group _____

(For Camp Use) Session Code(s): _____

# CAMPER HEALTH HISTORY FORM

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

**Immunization History:** Provide the month and year for each immunization. Starred (★) immunizations must include date to meet ACA Standard. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

| Immunization | Dose 1 Month/Year | Dose 2 Month/Year | Dose 3 Month/Year | Dose 4 Month/Year | Dose 5 Month/Year | Most Recent Dose Month/Year |
|---|---|---|---|---|---|---|
| Diptheria, tetanus, pertussis (DTaP) or (TdaP) | | | | | | |
| Tetanus booster★ (dT) or (TdaP) | | | | | | |
| Mumps, measles, rubella (MMR) | | | | | | |
| Polio (IPV) | | | | | | |
| Haemophilus influenzae type B (HIB) | | | | | | |
| Pneumococcal (PCV) | | | | | | |
| Hepatitis B | | | | | | |
| Hepatitis A | | | | | | |
| Varicella (chicken pox) ☐Had chicken pox Date: | | | | | | |
| Meningococcal meningitis (MCV4) | | | | | | |

| Tuberculosis (TB) test | Date: | ☐Negative ☐Positive |
|---|---|---|

**If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.**

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Camper: _____



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# CAMPER HEALTH HISTORY FORM

Developed and reviewed by: *American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses*

Camper Name: _____
First Middle Last

Birth Date: _____
Month/Day/Year

**General Health History:** ***Check "Yes" or "No" for each statement. Explain "Yes" answers below.***

Has/does the camper:

| | | | |
|---|---|---|---|
| 1. Ever been hospitalized? | ☐ Yes ☐ No | 11. Had fainting or dizziness? | ☐ Yes ☐ No |
| 2. Ever had surgery? | ☐ Yes ☐ No | 12. Passed out/had chest pain during exercise? | ☐ Yes ☐ No |
| 3. Have recurrent/chronic illnesses? | ☐ Yes ☐ No | 13. Had mononucleosis ("mono") during the past 12 months? | ☐ Yes ☐ No |
| 4. Had a recent infectious disease? | ☐ Yes ☐ No | 14. If female, have problems with periods/menstruation? | ☐ Yes ☐ No |
| 5. Had a recent injury? | ☐ Yes ☐ No | 15. Have problems with falling asleep/sleepwalking? | ☐ Yes ☐ No |
| 6. Had asthma/wheezing/shortness of breath? | ☐ Yes ☐ No | 16. Ever had back/joint problems? | ☐ Yes ☐ No |
| 7. Have diabetes? | ☐ Yes ☐ No | 17. Have a history of bedwetting? | ☐ Yes ☐ No |
| 8. Had seizures? | ☐ Yes ☐ No | 18. Have problems with diarrhea/constipation? | ☐ Yes ☐ No |
| 9. Had headaches? | ☐ Yes ☐ No | 19. Have any skin problems? | ☐ Yes ☐ No |
| 10. Wear glasses, contacts, or protective eyewear? | ☐ Yes ☐ No | 20. Traveled outside the country in the past 9 months? | ☐ Yes ☐ No |

***Please explain "Yes" answers in the space below,*** noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

**Mental, Emotional, and Social Health:** ***Check "Yes" or "No" for each statement.***

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
4. Had a significant life event that continues to affect the camper's life? ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

***Please explain "Yes" answers in the space below,*** noting the number of the questions. The camp may contact you for additional information.

**Health-Care Providers:**

Name of camper's primary doctor(s) - REQUIRED: _____ Phone: (_____) _____

Name of dentist(s): _____ Phone: (_____) _____

Name of orthodontist(s): _____ Phone: (_____) _____

**What Have We Forgotten to Ask?** ***Please provide in the space below*** any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program. ***Attach additional information if needed***.



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Recommendations for Licensed Medical Personnel

PHYSICIAN PHYSICAL FORM

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american CAMP association®

***Return this completed packet by email to the Andie Prabhu no later than July 1st, 2022.***

***aprabhu@ymcaoc.org***

***If you have any questions, call or email Andie Prabhu at 714.508.7671***

***To Parent(s)/Guardian(s): Complete this section and give this form (PHYSICIAN PHYSICAL FORM) and a copy of your completed CAMPER HEALTH HISTORY FORM to your child's health-care provider for review.*** Dates will attend camp: from _____ to _____
(Month/Day/Year) (Month/Day/Year)

Camper Name: _____
(First) (Middle) (Last)

☐ Male ☐ Female Birth Date _____ (Month/Day/Year) Age on arrival at camp _____

Camper home address: _____

_____
(City) (State) (Zip Code)

Custodial parent(s)/guardian(s) phone: (_____)_____ (_____)_____

***Parent(s)/guardian(s) stop here. Rest of form to be completed by medical personnel.***

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. ***Medical personnel: Cross out those items the camper should not be given.***

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Phenylephrine (Sudafed PE)
Pseudoephedrine (Sudafed)
Chlorpheneramine maleate
Guaifenesin
Dextromethorphan
Diphenhydramine (Benadryl)
Generic cough drops
Chloraseptic (Sore throat spray)
Lice shampoo or scabies cream (Nix or Elimite)
Calamine lotion
Bismuth subsalicylate (Pepto-Bismol)
Laxatives for constipation (Ex-Lax)
Hydrocortisone 1% cream
Topical antibiotic cream
Calamine lotion
Aloe

***Medical Personnel: Please review the CAMPER HEALTH HISTORY FORM and complete all remaining sections of this form. Attach additional information if needed.***

**Physical exam done today:** ☐ Yes ☐No **(If "No," date of last physical: _____)**
(Month/Day/Year)

**ACA accreditation standards specify physical exam within the last 24 months.**

Weight: _____ lbs Height: _____ft_____in Blood Pressure_____/_____

**Allergies:** ☐ No Known Allergies

☐ To foods ***(list)***:

☐ To medications: ***(list)***:

☐ To the environment ***(insect stings, hay fever, etc.– list)***:

☐ Other allergies: ***(list)***:

***Describe previous reactions:***

**Diet, Nutrition:** ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restrictions:(describe below)

**The camper is undergoing treatment at this time for the following conditions:** ***(describe below)*** ☐ None.

**Medication:** ☐ No daily medications. ☐ Will take the following prescribed medication(s) while at camp: ***(name, dose, frequency—describe below)***

**Other treatments/therapies to be continued at camp:** ***(describe below)*** ☐ None needed.

**Do you feel that the camper will require limitations or restrictions to activity while at camp?** ☐ No ☐ Yes

***If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)***

**"I have reviewed the CAMPER HEALTH HISTORY FORM, and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above.)**

Name of licensed provider (please print): _____ Signature: _____ Title: _____

Office Address_____
(Street) (City) (State) (Zip Code)

Telephone: (_____)_____ Date:_____

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Camper Name First Middle Last

(For Camp Use) Cabin or Group_____

(For Camp Use) Session Code(s):_____

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

# YMCA PHOTO/AUDIO VISUAL/NARRATIVE RELEASE

I am 18 years of age or older and, if not, my parent or legal guardian has also provided their consent by signing below.

**Consent & License.** For my participation in activities to be conducted by the YMCA of Orange County or any of its chartered member associations in the United States (collectively "the Y"), and collaborating third parties, I consent, now and for all time, to the making, reproduction, editing, broadcasting or rebroadcasting of:

- video film or footage of me,
- sound track recordings of me
- photo reproductions of me
- any narrative account of my experience

My consent includes a perpetual license to the Y and collaborating third-parties for the use of the above materials for publication, display, sale or exhibition in promotions, advertising, education and commercial uses. Use includes reproductions in any form and media currently existing or later conceived, adaptations and/or revisions, throughout the world in perpetuity.

I understand and agree there may be no additional compensation for this license, and I will not make any claim for payment of any kind from the Y or collaborating third-parties. I may, or may not be, identified in such licensed uses; however, my name will not be used to endorse any particular products or services.

**Ownership, Confidentiality, and Shared Use.** With respect to any of the above uses, I further agree:

- All works shall belong to YMCA of Orange County;
- The Y has no duty of confidentiality regarding any licensed uses;
- YMCA of Orange County shall exclusively own all known or later existing rights to the uses throughout the world;
- The Y and collaborating third-parties may use any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account for any purpose without additional compensation to me.

**Release from Liability.** I agree that my consent is irrevocable. I hereby release and discharge The Y and collaborating third-parties, from any and all claims, actions, lawsuits or demands of any kind arising out of my consent, license grants, uses, or the shared uses of any works or materials referenced herein.

Signature:_____ Date:_____

Printed Name: _____ Age: _____

Address: _____

_____

I am the parent or legal guardian of_____. I hereby consent and grant the licenses detailed in the foregoing on behalf of my minor child.

Signature of parent or legal guardian: _____

Printed name: _____

# YMCA PARTICIPANT SWIM ABILITY QUESTIONAIRE

The YMCA of Orange County has planned to take your child swimming this summer. This may include swimming at a YMCA pool, the local beach or a swim park.

In order for the YMCA director and teachers to provide a safe swim environment for your child the YMCA requests that you fill out this brief questionnaire on your child's swim capabilities.

Child's Name: _____ Child's Camp/School Site: Camp Oakes

PLEASE CHECK THE APPROPRIATE BOX:

| | | | |
|---|---|---|---|
| Can your child jump feet first in to the water at a depth of 5 feet or deeper? | YES ☐ | NO ☐ | Unsure ☐ |
| Can your child tread water for 10 seconds? | YES ☐ | NO ☐ | Unsure ☐ |
| Without grabbing the pool wall, can your child swim the front stroke with the ability to have their face in the water and take comfortable breaths? | YES ☐ | NO ☐ | Unsure ☐ |
| Can your child swim half the length of the pool? | YES ☐ | NO ☐ | Unsure ☐ |
| Can your child roll on to their back and float for 10 seconds? | YES ☐ | NO ☐ | Unsure ☐ |

Please fill out a separate questionnaire for each of your children in the program.

If you have any additional comments or remarks about your child's swimming capabililties please list them here: _____

_____

_____

Date: _____ Parent's Name: _____

Parent's Signature: _____

# YMCA OF ORANGE COUNTY

## TRANSPORTATION PASSENGER PROFILE

**Participant's Name:** _____ **Phone:** _____

**Site/Location Name:** Camp Oakes **Branch:** Overnight Camp

**Sex:** ***Male*** ☐ ***Female*** ☐ **Height:** _____ **Hair Color:** _____

**Birth Date:** _____ **Age:** _____ **Eye Color:** _____

**Session Date:** July 8-15, 2023

**For identification purposes, please attach a recent photo:**

**ATTACH PHOTO HERE**