



# TAKODAH YMCA – DEVELOPMENTAL TRAVEL HEALTH HISTORY FORM

GROUP: \_\_\_\_\_

Please note that the information on this form is NOT part of the student or staff acceptance process. The information is gathered only to assist Takodah YMCA staff in caring appropriately for your child. We require a NEW Health History Form every year. Please make a copy for your records.

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City State ZIP

### Emergency Contact Information

Primary Parent / Legal Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Secondary Parent / Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

If unavailable in an emergency, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home / Work / Cell Phone 1: \_\_\_\_\_ Home / Work / Cell Phone 2: \_\_\_\_\_

Do you plan to be away from home during tour? \*  No  Yes Dates: \_\_\_\_\_

\* If so, please remember to attach dates, locations, and contact information..

### Health Insurance

Is the student covered by family medical and/or hospital insurance?  No  Yes

Insurer Name: \_\_\_\_\_ Provider Services Phone: \_\_\_\_\_

Group #: \_\_\_\_\_ ID #: \_\_\_\_\_ Policy Effective Date: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber Birthdate: \_\_\_\_\_ Relationship: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist/Orthodontist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Health History Questions	Yes	No	Health History Questions	Yes	No
Asthma – Last Attack:			Frequent Ear Infections / Swimmer’s Ear		
Diabetes – Last HgbA1C:			Bleeding / Clotting Disorder		
Seizure Disorder – Last Seizure:			History of Bedwetting		
Eating Disorder			Hospitalization / Surgery – Date:		
Emotional Disorder (e.g. anxiety, depression)			Skin Problems		
Behavioral Disorder (e.g. ADHD, Asperger’s)			Orthopedic Problems		
Abnormal Menstrual History			Recent Illness or Infectious Disease		
Digestive Problems (e.g. diarrhea, constipation)			Sleep Disorder		
Frequent Headaches / Migraines			Diagnosed Concussion – Date:		

If you answered “Yes” to any questions above, please explain here: \_\_\_\_\_

Please describe any other physical, emotional, or behavioral issues, as well as any recent or ongoing treatments (attach additional pages as necessary): \_\_\_\_\_

Last Tetanus Immunization Date: \_\_\_\_\_

### Allergies

Describe Reaction and Management of Reaction

\_\_\_\_\_

### Restrictions

Dietary Restrictions:  None  No Red Meat  No Poultry  No Dairy  No Pork  No Eggs  No Gluten

Other Dietary Restriction: \_\_\_\_\_

Please describe any restrictions to activities on tour: \_\_\_\_\_

**Over The Counter Medications**

While we are on tour, we bring the following over the counter medications. If you wish to give permission for your child to be medicated if needed while on tour, please check any boxes that would apply.

Medication	Yes	No	Medication	Yes	No
<b>All Medications Listed Below</b>			Pepto-Bismol		
Dramamine or generic equivalent			Cough Drops		
Acetaminophen/Tylenol (pain, fever)			Sore Throat Lozenges		
Tums/ Chewable Antacid			Benadryl or generic equivalent (allergies)		
Anti-Diarrheal/ Imodium			Cough Syrup		
Ibuprofen/Advil/Motrin (pain, fever)					

Please list all medications your student will be taking while on tour:

Medication	Directions

**Parent / Guardian Authorization:** I attest that this health history is accurate and complete, and that the person described herein has permission to participate in all Takodah YMCA activities except as noted by me. I hereby give permission to Takodah YMCA to provide routine health care, including prescribed medications, and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission for Takodah YMCA to arrange necessary related transportation for me/my child. If I cannot be reached in an emergency, I hereby grant permission to the physician selected by Takodah YMCA to secure and administer treatment, including hospitalization, for the above named person. This completed form may be photocopied for use on tour.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent / Guardian Printed Name: \_\_\_\_\_