



HEALTH HISTORY AND EMERGENCY TREATMENT AUTHORIZATION

Family Name: _____ Phone: _____

Address: _____

E-Mail Address: _____

In case of emergency while we are at Camp Hazen YMCA, please contact:

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____ Relationship to Family: _____

NAMES:
Date of Birth					
COVID-19 Vaccination Date(s)					
If not vaccinated date of last negative test					
Have you had contact with anyone that has tested positive for COVID-19 in the past 2 weeks?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Do you have any symptoms of a respiratory infection (e.g. cough, sore throat, fever, or shortness of breath)?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Have you had a fever in the past 72 hours?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Are you a vegetarian?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Any pre-existing injuries (ankles, knees, back, etc) that might be aggravated by this event?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Taking any current medications?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Any heart problems or heart medication?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Do you have high blood pressure?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Do you have any allergies (food, bees, insects), reactions to medications or physical limitations?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

Please indicate any health history/problems you feel the Camp Hazen YMCA staff should be aware of:

I hereby grant Camp Hazen YMCA and its agents' full authority to take whatever action they deem necessary regarding my health in the case of an emergency where I am not able to make the decision. I fully release Camp Hazen YMCA and its agents from any liability in connection with those decisions. I grant permission for emergency treatment by a rescue squad, private physician and/or hospital or emergency health care facility staff, under the same circumstances as above, if needed. Any such action will be taken in my best interest.

Participant Signature*: _____ Date: _____ Participant Signature*: _____ Date: _____

Participant Signature*: _____ Date: _____ Participant Signature*: _____ Date: _____

Participant Signature*: _____ Date: _____

**If any participant is under the age of 18, their parent or guardian must also sign below:*

Signature of Parent/Guardian: _____ Date: _____



CAMP HAZEN YMCA

204 West Main St, Chester, CT 06412

T: (860) 526 9529 F: (860) 526 9520

INFORMED CONSENT/LIABILITY RELEASE

- I am aware and understand that participating in activities while at Camp Hazen, including the Alpine Tower, High Ropes Course, Climbing Wall, Low Ropes Course, skate boarding, in-line skating, mountain biking, water sports, field sports, aerobics and kickboxing involve a potential risk of physical injury. I also am aware and understand that all of the program activities are strictly voluntary, and it is my choice to participate in each activity to whatever degree I deem appropriate, after due consideration of my own physical health, physical abilities and medical condition.
- I agree that I am solely responsible for my own participation and for my own physical and emotional well- being. I will not be under the influence of any chemical substance, including alcohol, while participating. The health history presented to the camp is correct to the best of my knowledge.
 - I willingly, and knowingly assume for myself, my heirs, family members, executors, administrators, and assume all risk of physical injury and emotional upset which may occur during or after participating in any aspect of the program and to hold the YMCA, its employees, its instructors, facilitators and agents harmless for any liability arising out of my participation in the program. Should the YMCA or anyone acting on their behalf be required to incur attorney’s fees and costs to enforce this agreement, I agree to indemnify (to shift the responsibility for payment of damages to someone else) and hold the YMCA harmless for all such fees and costs. This release does not, however, apply to any physical injury or emotional harm caused by negligence or willful misconduct of the YMCA, its employees, its instructors, facilitators, and agents.
 - I authorize the YMCA to have and use photographs, slides and videotapes of the person named above as needed for its records and public relations programs.
 - I have had sufficient opportunity to read this entire document. I have read and understand it, and I agree to be bound by its terms.

COVID -19

Health Screening

All participants will be required to take part in a health screening upon arrival. A fever is considered over 100.44oF

Masks

All participants and staff are required to wear a mask, while inside any building (except sleeping area) or outside when at least 6 feet social distance cannot be maintained. We follow the TWO out of THREE rule. You just follow at least two of the following: be outside, wearing a mask or being 6ft away.

Social Distancing

During unstructured program time you are encouraged to maintain a minimum of 6ft between yourself and others.

Contact Tracing

In the event that there is a case of COVID-19 with a participant or staff member, you are recommended to keep track of individuals that you have been within 6ft of for greater than 15 minutes. Camp Hazen YMCA will provide contact information for all participants and staff members to the CT Dept of Health if required.

Informed Consent:

I hereby attest that I have been informed of the following pertaining to the coronavirus:

- People who are 65 years and older and people of any age who have serious underlying medical conditions or are at higher risk for severe illness from COVID-19 are recommended to stay at home. A list of medical conditions associated with a higher risk for severe illness from COVID-19 can be found in [CDC’s guidance](#). Individuals and families should consult their healthcare provider to determine whether they have medical conditions that place them at risk.
- Staff and children living in households with individuals who are 65 years and older OR have higher risk for severe illness from COVID-19 are recommended to stay home.

Participant Signature*: _____ Date: _____ Participant Signature*: _____ Date: _____

Participant Signature*: _____ Date: _____ Participant Signature*: _____ Date: _____

Participant Signature*: _____ Date: _____

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