



**Riverbrook Regional YMCA
Camp Gordyland Individual Care Plan**

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

Child's Name _____ Date of Care Plan ____/____/____ to ____/____/____

Child's Date of Birth ____/____/____

Special Health / Behavioral Concerns

If necessary, please specify on the line provided.

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies (food, medication, insects, environmental, etc.) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision / Hearing / Speech (glasses, ear tubes, etc.) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Illness _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Dietary Needs _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Developmental Variations _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional / Behavioral _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | History of Contagious Disease _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Symptoms / Medication / Process of Care

For each " Yes " answer listed above, please provide the following information.

#1 Health Concern: _____
 Symptoms: _____
 On-Site Medication: Yes No _____
 Steps of Care: _____
 1. _____
 2. _____
 3. _____
 4. _____
 Additional Information: _____

Continued on reverse side.

#2 Health Concern: _____
 Symptoms: _____
 On-Site Medication: Yes No _____
 Steps of Care: _____
 1. _____
 2. _____
 3. _____
 4. _____
 Additional Information: _____

#3 Health Concern: _____
 Symptoms: _____
 On-Site Medication: Yes No _____
 Steps of Care: _____
 1. _____
 2. _____
 3. _____
 4. _____
 Additional Information: _____

Name of Health Care Provider: _____ **Phone:** (____) _____

Parent / Guardian Signature: _____ **Date:** _____

** For Administrative Use Only **	
Mike Kazlauskas, Camp Director: _____	Date: _____
Kim Murphy, Senior Childcare & Day Camp Director: _____	Date: _____
Camp First Aid Director: _____	Date: _____
Assistant Camp First Aid Director: _____	Date: _____
Additional First Aid Director: _____	Date: _____
Unit Director: _____	Date: _____
Age Group Director: _____	Date: _____
Counselor: _____	Date: _____
Counselor: _____	Date: _____
Counselor: _____	Date: _____
Counselor: _____	Date: _____