FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Southington-Cheshire Community YMCA
Camp Sloper Individual Care Plan

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

Child's Date of Birth ___/___/___ Program Site: YMCA Camp Sloper

Special Health / Behavioral Concerns
If necessary, please specify on the line provided.

Yes	No	
☐	☐	Allergies (food, medication, insects, environmental, etc.) _____
☐	☐	Asthma _____
☐	☐	Vision / Hearing / Speech (glasses, ear tubes, etc.) _____
☐	☐	Chronic Illness _____
☐	☐	Diabetes _____
☐	☐	Seizures _____
☐	☐	Dietary Needs _____
☐	☐	Developmental Variations _____
☐	☐	Emotional / Behavioral _____
☐	☐	History of Contagious Disease _____
☐	☐	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.

SOUTHINGTON-CHESHIRE COMMUNITY YMCAs
29 High Street, Southington, CT 06489
P 860-628-5597 F 860-628-6499 www.sccymca.org

#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 **

Justin Hubeny, Camp Director: _____ Date: _____

Tom Sangeloty, Asst. Camp Dir.: _____ Date: _____

Sarah Dupre, Outdoor Cntr. Admin.: _____ Date: _____

Olivia Sherman, Spec. Needs Coord.: _____ Date: _____

Unit Director: _____ Date: _____

Unit Director: _____ Date: _____

PW Counselor: _____ Date: _____

S1 Counselor: _____ Date: _____

S2 Counselor: _____ Date: _____

S3 Counselor: _____ Date: _____

S4 Counselor: _____ Date: _____

Nurse Signature _____ Date: _____

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