

Camp Nazareth 2011

Office of Youth and Young Adults

Archeprarchy of Pittsburgh

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HEALTH HISTORY and EXAMINATION FORM

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist in identifying appropriate care. The health history portion must be filled out by parents/guardians of minors or by adult staff themselves. Additionally, a medical exam is required within 12 months of the camping session. If an exam was already done in that time period, your physician may be willing to fill out the form without an additional examination, but must still fill out and sign this form. The medical form on the last page must be completed and signed by an approved, licensed medical professional. Please be sure this entire form is complete. This form follows the strictest codes of the ACA and is necessary. Thank you for your cooperation

NAME: _____
Last First Middle

BIRTH DATE: _____ AGE: _____ GENDER: M F

HOME ADDRESS: _____
Street Address City State Zip

CUSTODIAL PARENT/GAURDIAN: _____

HOME PHONE: _____ WORK PHONE: _____

SECONDARY PARENT/GAURDIAN/EMERGENCY CONTACT: _____

HOME PHONE: _____ WORK PHONE: _____

IF NEITHER ARE AVAILABLE, PLEASE CONTACT: _____

RELATIONSHIP: _____ PHONE: _____

INSURANCE INFORMATION: Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name: _____ Group #: _____

THE FOLLOWING MUST BE COMPLETE FOR ATTENDANCE

This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer over-the-counter medications, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests for me/my child. I agree to the release of any records necessary for treatment referral, billing or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment including hospitalization, for the person named above. I understand that my insurance coverage for my child will be used as primary coverage in the event medical intervention is needed. I further understand that I will be responsible for any expenses not covered by my insurance. I understand all reasonable safety precautions will be taken at all times by Camp Nazareth and its agents during camp. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold the American Carpatho-Russian Orthodox Diocese, Camp Nazareth, their leaders, employees, and/or volunteer staff liable for damages, losses, diseases, or injuries incurred by the subject of this form. I agree that my child will abide by all of the rules and guidelines set forth by Camp Nazareth for the order, safety, and good health of the campers at camp. I give permission for my child to participate in all camp activities. I also agree that if my child has to return home due to discipline violations, it will be at my own expense. I agree to indemnify and hold harmless, the American Carpatho-Russian Orthodox Diocese, Camp Nazareth, their leaders, employees, and/or volunteers from any expenses, loses, claims, or damages incurred as a result of the acts or omissions of the subject of this form. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper/staffer: _____

Print Name: _____ Date: _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities and will comply with all of the reasonable requests made by the Camp Nazareth Staff in regards to order, safety, and good health.

Signature of **minor camper** or **adult camper/staffer**: _____ Date: _____

Health History

The parent or guardian or adult camper or staff member must fill in the following information. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records if you wish. Any changes to this form should be provided to camp health personnel upon participant's arrival at the camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES

Describe reaction and management of reaction

_____	_____
_____	_____
_____	_____
_____	_____

FOOD ALLERGIES

_____	_____
_____	_____
_____	_____
_____	_____

OTHER ALLERGIES

_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS CURRENTLY BEING TAKEN

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. ALL medications must be turned over to the camp medical personnel upon arrival, no exceptions. If your child must have any medications (prescription and non-prescription included) on his/her person, this **must** be acknowledged by the medical personnel, in writing, on the final page.

Please check here to indicate if the person being represented by this form takes no medications whatsoever:

Med #1: _____ Dosage : _____ Specific Times taken each day: _____

Reason for taking: _____

Med #2: _____ Dosage : _____ Specific Times taken each day: _____

Reason for taking: _____

Med #3: _____ Dosage : _____ Specific Times taken each day: _____

Reason for taking: _____

Attach Additional Page if Necessary.

Identify any medications taken normally or during the school year that the participant does/may not take during summer and why:

RESTRICTIONS

Please list here any restrictions to activities that are medically necessary (i.e. what cannot be done, what adaptations or limitations necessary):

OVER-THE-COUNTER MEDICINES:

Please circle Yes or No to each over-the-counter medication that your child is permitted to take while at Camp Nazareth:

Aspirin	-	Yes	No	Pepto Bismol	-	Yes	No	Antacids	-	Yes	No
Tylenol	-	Yes	No	Cough Syrup	-	Yes	No	Antiseptic Throat Spray	-	Yes	No
Advil	-	Yes	No	Cough Lozenges	-	Yes	No	Sterile Eye Irrigate	-	Yes	No
Benadryl	-	Yes	No	External Ointments	-	Yes	No	Sudafed	-	Yes	No
				Sprays, or Lotions							

Please list any other over-the-counter medicines that you specifically do not want administered, if any exist:

GENERAL QUESTIONS: (Explain "Yes" answers below)

Has/Does the participant have?

- | | | | | | |
|---|-----|----|---|-----|----|
| 1. Had any recent injury, illness, or disease? | Yes | No | 17. Ever had joint problems (i.e. knees, ankles, etc.)? | Yes | No |
| 2. Have a chronic or recurring illness/condition? | Yes | No | 18. Have an Orthodontic appliance being brought to camp? | Yes | No |
| 3. Ever been hospitalized? | Yes | No | 19. Have any skin problems? (itching, rash, acne, etc.)? | Yes | No |
| 4. Ever had surgery? | Yes | No | 20. Have Diabetes? | Yes | No |
| 5. Have frequent headaches? | Yes | No | 21. Have Asthma? | Yes | No |
| 6. Ever had a head injury? | Yes | No | 22. Had mononucleosis in the past year? | Yes | No |
| 7. Ever been knocked unconscious? | Yes | No | 23. Had problems w/diarrhea/constipation? | Yes | No |
| 8. Wear glasses, contacts, or protective eyewear? | Yes | No | 24. Ever had an eating disorder? | Yes | No |
| 9. Ever had frequent ear infections? | Yes | No | 25. If female, have an abnormal menstrual history? | Yes | No |
| 10. Ever passed out during or after exercise? | Yes | No | 26. Ever had emotional difficulties for which professional help was sought? | Yes | No |
| 11. Ever been dizzy during or after exercise? | Yes | No | | | |
| 12. Ever had seizures? | Yes | No | | | |
| 13. Ever had chest pain during or after exercise? | Yes | No | | | |
| 14. Ever had high blood pressure? | Yes | No | | | |
| 15. Ever been diagnosed with a heart murmur? | Yes | No | | | |
| 16. Ever had back problems? | Yes | No | | | |

Please explain any "Yes" answers, noting the number of the question. (Use additional pages if necessary)

Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

TB Mantoux Test

Date of last test _____

Result: Positive Negative

PLEASE GIVE ALL DATES OF IMMUNIZATION FOR:

- DTP _____
- TD (Tetanus/Diphtheria) _____
- Tetanus _____
- Polio _____
- MMR _____
- or Measles _____
- or Mumps _____
- or Rubella _____
- Haemophilus Influenza B _____
- Hepatitis B _____
- Varicella _____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Name of family physician: _____ Phone: _____

Address: _____

Name of family Dentist/Orthodontist: _____ Phone: _____

Address: _____

HEALTH HISTORY RECOMMENDATIONS

To be filled out and signed by a **Licensed Medical Professional**

I examined this individual on the date of: _____

(Camp Nazareth requires an annual exam, as allowed by the ACA. This exam is **required** for camp attendance. If the camper or staffer has received a physical exam in the last year, another exam is not required, however, this form must still be filled out and signed by the Medical professional who had performed that physical.)

Blood Pressure: _____ Height: _____ Weight: _____

In my opinion, the above applicant **is** or **is not** able to participate in this summer's active camp program.

The applicant is under the care of a physician for the following conditions: _____

Recommendations and Restrictions at Camp

Treatment to be continued at camp: _____

Medications to be administered at camp (name, dosage, frequency): _____

Any medically prescribed meal plan or dietary restrictions: _____

Known Allergies: _____

Description of any limitation or restriction on camp activities: _____

Additional information for health care staff at the camp: _____

Signature of Licensed Medical Professional: _____

Printed Name: _____ Title: _____

Address: _____

Phone: _____ Date: _____

The section below is for Camp Personnel use only, please disregard:

Screening Record at Check-In

Date Screened: _____ Time: _____ am/pm

Medications received (Prescription and non-prescription): _____

Updates/additions to health history? Yes No If yes,

Current health needs identified? _____

Observational notes: _____

