CAMP St. Raphael

**Send completed to:**
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american CAMP association ACCREDITED

# Health History and Examination Form - 2012

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. The health history portion must be filled out by parents/guardians of minors or by adults 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. The medical exam form on the last page must be completed and signed by approved licensed medical personnel.

Name: ____________________________________________ Birthdate: ____________
Last First MI

Age while attending camp: ________ Gender: □ Male □ Female Session: □ I (one) □ II (two)

Home Address: ____________________________________________________________
Street Address City State/Prov. Zip

Custodial parent/guardian(s):

Mother ____________________ Phone: (h)____________ (w)____________ (cell)____________

Father ____________________ Phone: (h)____________ (w)____________ (cell)____________

Mother's Email____________________________Father's email____________________

Other Emergency Contact Name: ____________________________ Home Phone: ____________

Relationship to Camper: ________________________ Other Phone: ____________

Name of family physician ____________________________ Phone: ____________

**Health Insurance:** Is the participant covered by family medical/hospital insurance? (*Please check one of the boxes below)*

□ Yes **A photocopy of the front and back of your health insurance card must be attached to this form.**
□ No At this time we do not have health insurance but will be responsible for all expenses incurred.

# Health History & Information

**The following information must be filled in by the parent/guardian, or adult camper or staff member.** The intent of this information is to provide camp health care personnel the background to provide appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival to camp. Please provide complete information so that the camp can be aware of your health needs.

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 DATES OF IMMUNIZATION FOR:**

DTP ____________________
TD (tetanus/diphtheria) ____________________
Tetanus ____________________
Polio ____________________
MMR ____________________
or Measles ____________________
or Mumps ____________________
or Rubella ____________________
Haemophilus influenca B ____________________
Hepatitis B ____________________
Varicella (chicken pox) ____________________

 ***Camper Name*** ____________________

**ALLERGIES** **Describe reaction and management of reaction**

**Medication Allergies**

____________________ ____________________

____________________ ____________________

**Food Allergies**

____________________ ____________________

____________________ ____________________

**Other Allergies** (include insect stings, hay fever, asthma, animal dander, etc.)

____________________ ____________________

____________________ ____________________

**MEDICATIONS CURRENTLY BEING TAKEN (Meds brought to camp *must* be in their original labeled pharmacy container.)**

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 pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer: ____________________

________________________________________

**OVER-THE-COUNTER MEDICINES**

**Please circle Yes or No next to each over-the-counter medication that your child is permitted to take.**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Tylenol Products | Yes | No | Pepto Bismol | Yes | No | Antacids | Yes | No |
| Ibuprofen Products | Yes | No | Cough Syrup | Yes | No | Antiseptic Throat Spray | Yes | No |
| Benadryl | Yes | No | Cough Lozenges | Yes | No | Sterile Eye Irrigate | Yes | No |
| | | | External Ointments, Sprays, Lotions | Yes | No | Sudafed | Yes | No |

**GENERAL QUESTIONS** (Explain "yes" answers below.)

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

**Please explain any "yes" answers, noting the number of the questions.** (use additional pages if necessary)

________________________________________

________________________________________

 ***Camper Name*** ______________________________

**OTHER CAMPER INFORMATION**

We want your camper to have the best possible experience while at Camp St. Raphael. All information is regarded as STRICTLY CONFIDENTIAL and will only be shared with the staff who will be working with your camper and other necessary personnel (Camp Director, Nurse, etc.) as appropriate.

- What is your child looking forward to at camp? ______________________________
- Are there special fears, worries or concerns your child has about camp (extreme shyness, afraid of the dark, etc.)?

______________________________

- Are there circumstances in your child's life that would be helpful for us to be aware of (i.e., death of a close relative, divorce, or other family trauma, etc.)? Please provide relevant details.______________________________

______________________________

______________________________

- My camper is under the legal custodial care of: □ Both Parents □ Mother only □ Father only

□ Other ______________________ Please give all relevant details: ______________________

______________________________

Please note that if any restrictions regarding parental access to the camper are to be observed by the Camp, we must be notified via court order, addressed specifically to Camp St. Raphael.

- Sleep Habits: □ Sleep walks □ Wets bed □ Other:______________
- Has the camper ever been away to overnight camp before? □ Yes □ No
- Has the camper been away from home for more than two consecutive days? □ Yes □ No
- Swimming ability: □ Cannot Swim □ Beginner □ Intermediate □ Expert

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

______________________________

**PARENT/GUARDIAN AUTHORIZATIONS, PERMISSIONS AND AGREEMENT**

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. 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 St. Raphael and its agents during camp. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. If my child is injured and needs outside medical attention, I understand all possible means will made by Camp St. Raphael to contact the parent/guardian. I agree not to hold the Antiochian Orthodox Christian Archdiocese, Camp St. Raphael, Greater Tulsa YMCA, 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 the rules and guidelines set forth by Camp St. Raphael for the safety and good health of the campers at camp. 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 Antiochian Orthodox Christian Archdiocese, Camp St. Raphael, Greater Tulsa YMCA, 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.

I give permission for the use of any video images, photographs, audio recordings, or any other visual or audio reproduction that may be taken of my child during camp to be used in a camp video, camp website, for promotional purposes of the camp, or shown as CSR sees fit.

I give permission for my child to participate in all camp activities, with the exception of the following (please list reason for each activity denied):

| Activity | Reason for Denial of Permission |
| --- | --- |
| ______________ | ______________________________ |

**Signature of parent/guardian or adult camper/staff** ______________________________

**Printed Name** ______________________________ **Date**______________________

**If for religious reasons you cannot sign this, contact the camp office for a legal waiver which must be signed for attendance*

 ***Camper Name*** ______________________________

**HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL**

**Must be completed by a licensed medical person, NOT the parent.**

I examined this individual on ________________________.

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

________________________________________________________________________________

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

________________________________________________________________________________

Treatment to be continued at camp: ________________________________________________________________

________________________________________________________________________________

Any medically-prescribed meal plan or dietary restrictions: ________________________________________________

________________________________________________________________________________

Known allergies: ________________________________________________________________________

________________________________________________________________________________

Description of any limitation or restriction on camp activities: ________________________________________________

________________________________________________________________________________

□ Applicant does **NOT** have permission to participate in the Ropes Course

Additional information for health care staff at the camp: ________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**BP :** ________________________ **Weight:** ________________ **Height:** ______________

In my opinion, the above applicant □ is □ is not able to participate in an active camp program.

**Signature of Licensed Medical Personnel:** ________________________________________________

Printed: ________________________________________________ Date: ________________________

Address: ________________________________________________________________________

Phone: ________________________________ Fax: ________________________________

*For camp use only*

**SCREENING RECORD**

Date screened ______________________ Time ______________ Screened by ____________

Meds Received ________________________________________________________________

________________________________________________________________

________________________________________________________________

Updates/additions to health history noted □ Yes □ No □ None required

Current health needs identified ________________________________________________________

________________________________________________________________________________