ST. XENIA ORTHODOX CHURCH CAMP

Health History and Examination Form

Health history must be filled out by parents/guardians of minors. Update required annually.
Health exam (page 4) must be completed every two years.

Name_____ Birth Date_____
Last First Middle M/D/Y

Home Address_____
Street Address City State Zip

Social Security_____-_____-_____ Gender: *(Check)* Male____ Female____ Age at Camp_____

Custodial parent/guardian_____ Phone _____

Home Address_____
(if different from above) Street Address City State Zip

Business Address_____ Phone (_____)_____-_____
Street Address City State Zip

Second Parent or Guardian or Emergency Contact_____

Address_____ Phone (_____)_____-_____
Street Address City State Zip

Business Address_____ Phone_(_____)_____-_____

If not available in an emergency, notify:
Name_____

Relationship _____Phone (_____)_____-_____

Address_____
Street Address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? *(check)* Yes___ No___
If so, indicate carrier or Plan Name_____ Group #_____

☐ ***Photocopy of front and back of health insurance card must be attached to this form.***

Important – This Box must be completed for attendance.*

Parent/Guardian Authorizations:

This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities as noted.

I hereby give permission to the camp to provide routine health care, 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. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian_____

Printed Name_____ **Date**_____

I also understand and agree to abide by restrictions placed on my participation in camp activities

Signature of camper_____**Date**_____

Health History
The following information must be filled in by the parent/guardian. 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. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your child's/your needs.

ALLERGIES List all Known. Describe reaction and management of the reaction

Medication Allergies (list)

_____ _____
_____ _____
_____ _____
_____ _____

Food Allergies (list)

_____ _____
_____ _____
_____ _____

Other Allergies (list) – Include insect stings, hay fever, asthma, animal dander, etc.

_____ _____
_____ _____
_____ _____

Medications Being Taken

Please list ALL medications (including over-the counter or nonprescription 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.

This person takes No Medications on a routine basis. (check) ____

This person takes medications as follows: (check) ____

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:_____

_____

RESTRICTIONS: The following restrictions apply to this individual. (Check the following)

Dietary:

_____Does not eat red meat _____Does not eat pork _____ Does not eat eggs
_____Does not eat poultry _____Does not eat seafood _____ Does not eat dairy products
_____Other (describe)_____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

_____
_____

General Questions (explain "yes" answers below)

Has/does the participant:

1.Had any recent injury, illness or infectious disease?…Yes___ No___
2. Have a chronic or recurring illness/condition?……Yes___ No___
3. Ever been hospitalized?……...Yes___ No___
4. Ever had Surgery?……Yes___ No___
5. Have frequent headaches?……Yes___ No___
6. Ever had a head injury?……Yes___ No___
7. Ever been knocked unconscious?……..Yes___ No___
8. Wear glasses, contacts or protective eyewear?…….Yes___ No___
9. Ever had frequent ear infections?……..Yes___ No___
10. Ever passed out during or after exercise?……...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 had diagnosed with a heart murmur?……..Yes___ No___
16. Ever had back problems?……Yes___ No___
17. Ever had problems with joints? (e.g. knees, ankles)? Yes___ No___
18. Have an orthodontic appliance being brought to camp?……Yes___ No___
19. Have any skin problems (e.g. itching, rash, acne)?…..Yes___ No___
20. Have diabetes?……Yes___ No___
21. Have asthma?……...Yes___ No___
22. Had mononucleosis in the past 12 months?……Yes___ No___
23. Had problems with diarrhea/constipation?……Yes___ No___
24. Have problems with sleepwalking?……..Yes___ No___
25. If female, have an abnormal menstrual history?……...Yes___ No___
26. Have a history of bed-wetting?……Yes___ No___
27. Ever had an eating disorder?……Yes___ No___
28. Ever had emotional difficulties for which professional help was in sought?……..Yes___ No___

Please explain any "yes" answers, noting the number of the questions.

_____

_____

_____

_____

_____

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:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____				
or Measles	_____	_____				
or Mumps	_____	_____				
Or Rubella	_____	_____				
Haemophilus influenza B	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____				
Varicella (chicken pox)	_____	_____				

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_____

St. Xenia Orthodox Church Camp - Health Care Recommendations by Licensed Medical Personnel

I examined this individual on _____. (Requires exam within 24 months of camp attendance.)
BP_____ Weight_____ Height_____

In my opinion, the above applicant is___ is not___ able to participate in an active camp program.
The applicant if 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 Personnel*_____

Printed_____Title_____

Address_____

Phone_____Date_____

For Camp Use Only

Screening Record

Date screened_____ Time_____am / pm

Meds received_____

_____

Updates/additions to health history noted Yes_____ No_____ None Required_____

Current health needs identified_____

_____

Observational notes_____

_____

Screened By _____

You have two options to submit:

1) Please scan and email the completed form and copy of your health insurance card if applicable to: Catrin Thorp at catherinethorp325@gmail.com
2) Please mail completed form, through traditional mail ASAP to:

Catrin Thorp
St. Xenia Camp Registrar
24 Amherst Street #2
Roslindale, MA 02131-3005

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Contact Info:

Catrin Thorp

St. Xenia Camp Registrar
Phone: (617) 372-3317
Fax (617) 832-7000
Email: catherinethorp325@gmail.com

If you have any questions about this form or the general registration process, please call Catrin Thorp.

IMPORTANT: The registration process is not complete until the signed medical (and the Parental consent form submitted online) are received by the camp registrar. Upon completion of this medical form, please email/mail it right away!