

St. Nicholas Camping Program

Email: john@campstnicholas.com

www.campstnicholas.com



Mail To: St. Nicholas Camping Program

Jonathan Geleris

P.O. Box 7100

La Verne, CA 91750

PLEASE CIRCLE: SESSION: 1 2 3

PLEASE RETAIN A COPY

Health History and Examination Form

THE HEALTH HISTORY FORM AND MEDICAL EXAM FORM MUST BE COMPLETED, SIGNED, AND POSTMARKED NO LATER THAN JUNE 30TH. IF IT IS POSTMARKED AFTER JUNE 30TH, A \$25 LATE FEE WILL BE ADDED TO YOUR ACCOUNT.

Name: _____ Birthdate: _____

Last

First

MI

Age while attending camp: _____ Gender: Male Female

Home Address: _____

Street Address

City

State/Prov.

Zip

Custodial parent/guardian(s): _____ Home Phone: _____

Other Phone: _____

Home Phone: _____

Other Phone: _____

Other Emergency Contact Name: _____ Home Phone: _____

Other Phone: _____

Name of family physician _____ Phone: _____

Name of family dentist/orthodontist _____ Phone: _____

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 INSURANCE CARD MUST BE ATTACHED TO THIS FORM.

Carrier or plan name: _____

Group #: _____ I.D. #: _____

No IF THE CAMPER DOES NOT HAVE HEALTH INSURANCE, PLEASE SIGN BELOW TO COMFIRM THAT THE PARENT/GUARDIAN OF THE CAMPER WILL TAKE SOLE RESPONSIBILITY FOR ANY AND ALL MEDICAL EXPENSES AND COSTS THAT MAY OCCUR, INCLUDING BUT NOT LIMITED TO EMERGENCY HEALTH CARE AND TREATMENT. Signature of Parent/Guardian _____

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 influenza B _____

Hepatitis B _____

Varicella (chicken pox) _____

**Immunization Dates
are REQUIRED**

NAME _____ SESSION(S) _____

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. They *must* be given to appropriate medical staff at time of Check-In)

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

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

NAME _____ SESSION(S) _____

OTHER CAMPER INFORMATION

We want your camper to have the best possible experience while at Camp St. Nicholas. 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, Food Service Director, 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. Nicholas.

•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

* I give permission for the camp to administer swim lessons, should they be available during the session.

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 the St. Nicholas Camping Program 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 Antiochian Orthodox Christian Archdiocese, the Southern California Deanery, St. Nicholas Camping Program, 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 the camp 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, the Southern California Deanery, St. Nicholas Camping Program, their leaders, employees, and/or volunteers from any expenses, losses, 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 any necessary trips out of camp. By signing this form, I also authorize St. Nicholas Camping Program to use photographs of my child in camp/Archdiocese publications and websites. 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):

<i>Activity</i>	<i>Reason for Denial of Permission</i>
_____	_____
_____	_____

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*

NAME _____ SESSION(S) _____

THE MEDICAL EXAM IS REQUIRED WITHIN 12 MONTHS OF THE CAMPING SESSION. THIS PAGE MUST BE COMPLETED AND SIGNED BY APPROVED LICENSED MEDICAL PERSONNEL AND POSTMARKED NO LATER THAN JUNE 30TH. IF IT IS POSTMARKED AFTER JUNE 30TH, A \$25 LATE FEE WILL BE ADDED TO YOUR ACCOUNT.

HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL

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: _____

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: _____