St. Nicholas Camping Program
Email: office@campstnicholas.com
www.campstnicholas.com

Before July 1, mail to:
St. Nicholas Camping Program
c/o Luke Pettygrove
9730 Park Street, Apt 10
Bellflower, CA 90706

Or email anytime:
office@campstnicholas.com

STAFF HEALTH FORMS

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 15TH.

Name: ______________________________ Birthdate: ____________
Last First MI

Age while attending camp: ________ Gender: ❑ Male ❑ Female

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

Other Phone: ____________

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 YOU DO NOT HAVE HEALTH INSURANCE, PLEASE SIGN BELOW TO COMFIRM THAT THEYOU WILL TAKE SOLE RESPONSIBILITY FOR ANY AND ALL MEDICAL EXPENSENES AND COSTS THAT MAY OC CUR, INCLUDING BUT NOT LIMITED TO EMERGENCY HEALTH CARE AND TREATMENT.

Signature of Staff Member ______________________

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 or a signed statement giving reason for exemption

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 with the correct dosage and administration instructions. 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.

Medication			Medication			Medication		
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)

____

____

(Continue on Back)

NAME ___________________________

ADDITIONAL INFORMATION

We want you to have the best possible experience while working at Camp St. Nicholas. All information is regarded as STRICTLY CONFIDENTIAL and will only be shared with necessary personnel (Camp Director, Nurse, Food Service Director, etc.) as appropriate.

- Are there special fears, worries or concerns you have about camp ___________________________

- Are there circumstances in your 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.___________________________

- Sleep Habits: ❑ Sleep walks ❑ Wets bed ❑ Other:______________________
- Swimming ability: ❑ Cannot Swim* ❑ Beginner ❑ Intermediate ❑ Expert

STAFF MEMBER/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 person named above. I understand that my insurance coverage 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 Southern California Deanery 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 I will abide by all the rules and guidelines set forth by the camp for the safety and good health of the other staff members and campers at camp. I also agree that if I have 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, 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 any necessary trips out of camp. By signing this form, I also authorize St. Nicholas Camping Program to use photographs of me in camp/Archdiocese publications and websites. I agree 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 staff member ___________________________

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 ____________________________

THE MEDICAL EXAM IS REQUIRED WITHIN 12 MONTHS OF THE CAMPING SESSION. THIS PAGE MUST BE COMPLETED AND SIGNED BY AN APPROVED LICENSED MEDICAL PERSONNEL AND POSTMARKED BY JUNE 15TH.

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: ____________________________________