

St. Nicholas Camping Program

Email: office@campstnicholas.com

www.campstnicholas.com



Mail To: St. Nicholas Camping Program

c/o Luke Pettygrove
1823 Westwood Place
Pomona, CA 91768

STAFF & VOLUNTEER 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 20TH.

SD

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 CONFIRM 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 or Volunteer _____

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.

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

GENERAL QUESTIONS (Explain "yes" answers below.)

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

(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/VOLUNTEER 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, 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 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):

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

Signature of staff member or volunteer _____

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 20TH.

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: _____