CAMP TRANSFIGURATION

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Staff Medical Form

INSTRUCTIONS

The information on this form is not part of the staff acceptance process. The intent of gathering this information is to provide camp health care personnel with an individual's medical history such that appropriate care may be offered. Any changes to this form must be given to the camp health care personnel upon arrival at camp. Please provide COMPLETE information so that the camp may be aware of your health needs. All information is regarded as STRICTLY CONFIDENTIAL and will only be shared with the camp health care staff and other necessary personnel (Camp Director, Camp Assistant Director, Nurse, Kitchen Coordinator, etc.), as appropriate.

→FULL NAME:			
SEX: ☐ Male ☐ Female	**DATE OF BIRTH:** _____ / _____ / _____ *Month Day Year*		*AGE WHILE ATTENDING CAMP:*
ADDRESS: _____ *(Street, include Apt. number) City Prov./State Postal/Zip Code Country*			
EMERGENCY CONTACT:	*NAME:*	*RELATION:*	
	HOME #	*WORK #*	*CELL #*
FAMILY PHYSICIAN:	*NAME:*	*PHONE #*	

HEALTH INSURANCE – REQUIRED FOR ALL IN ATTENDANCE

For Canadian residents: Please be sure to bring along your provincial Medicare card.

Medicare Card #: _____

For U.S. residents: A photocopy of the front and back of your health insurance card must be attached to this form.

Carrier/Plan Name: _____

Group #: _____

ID #: _____

GENERAL QUESTIONS

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 motion sickness?	☐	☐
13. Been known to have nightmares?	☐	☐
14. Ever had seizures?	☐	☐
15. Ever had chest pain during or after exercise?	☐	☐
16. Ever had high blood pressure?	☐	☐
17. Ever been diagnosed with a heart murmur?	☐	☐
18. Ever had back problems?	☐	☐
19. Ever had joint problems (i.e., knees, ankles)?	☐	☐
20. Have an orthodontic appliance being brought to camp?	☐	☐
21. Have any skin problems (i.e., itching, rash, acne)?	☐	☐
22. Have diabetes?	☐	☐
23. Have asthma?	☐	☐
24. Had mononucleosis in the past year?	☐	☐
25. Had problems with diarrhea/constipation?	☐	☐
26. Ever had an eating disorder?	☐	☐
27. If female, have an abnormal menstrual history?	☐	☐
28. Ever had emotional difficulties for which professional help was sought?	☐	☐
29. Ever had bleeding disorders?	☐	☐
30. Have fainting spells?	☐	☐
31. Have chronic cramps?	☐	☐
32. Ever had convulsions?	☐	☐
33. Have HIV?	☐	☐
34. Ever had a hernia?	☐	☐

Please explain any 'Yes' answers, noting the number of the questions. (Use additional pages if necessary)

_____

_____

_____

OVER-THE-COUNTER MEDICINE

Please circle 'Yes' or 'No' next to each over-the-counter medication that you wish to take if need be.

[Yes / No] Tylenol Products	[Yes / No] Pepto Bismol	[Yes / No] Antacids
[Yes / No] Ibuprofen Products	[Yes / No] Cough Syrup	[Yes / No] Antiseptic Throat Spray
[Yes / No] Dimetapp Products	[Yes / No] Cough Lozenges	[Yes / No] Sterile Eye Irrigate
[Yes / No] Mucinex Products	[Yes / No] Sudafed	[Yes / No] External Ointments
[Yes / No] Benadryl Spray/Lotion/Pill	[Yes / No] Gravol	Other 'No': _____

MEDICATIONS CURRENTLY BEING TAKEN

Please indicate if help is needed administering the medication, as well as if specific storage is needed (ex: refrigeration). Note: Meds brought to camp must be in their original labeled pharmacy container.

Med #1: _____ Dosage: _____ Form (pill/inhalation/injection) _____Times/day _____

Reason for taking: _____

Med #2: _____ Dosage: _____ Form (pill/inhalation/injection) _____Times/day _____

Reason for taking: _____

Med #3: _____ Dosage: _____ Form (pill/inhalation/injection) _____Times/day _____

Reason for taking: _____

Attach additional pages for more medications, as needed.
List any other medications regularly taken (i.e. fall/winter/spring) that you do not take during the summer:

_____

NAME:_____

HEALTH HISTORY

Which of the following infections have you had?

- ☐ Measles
- ☐ Chicken Pox
- ☐ Rubella (German Measles)
- ☐ Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

TB Mantoux Test (aka PPD):

Date of last test: _____

Result: ☐ Positive
☐ Negative

Please give dates of immunization for: (or photocopy immunization booklet)

Diphtheria/Tetanus/Pertussis/Polio (DTaP-IPV)… _____

Tetanus/Diphtheria (Tdap)…… _____

Tetanus booster (Td)…….... _____

Pneumococcus…….. _____

MMR…… _____

Meningococcus…… _____

Haemophilus influenzae B (HIB)…….. _____

Hepatitis B…… _____

Varicella (chicken pox)…….. _____

OTHER INFORMATION

All information is regarded as STRICTLY CONFIDENTIAL and will only be shared with the necessary personnel (Camp Director, Assistant Director, Nurse, Kitchen Coordinator, etc.) as appropriate.

- Date of last physical examination: _____
- Dietary restrictions: ☐ None ☐ Vegetarian ☐ Vegan ☐ Diabetic ☐ Other: _____
- Swimming ability: ☐ Cannot swim ☐ Beginner ☐ Intermediate ☐ Expert
- 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.

_____

_____

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

_____

_____

_____

ALLERGIES

Describe reaction and management of reaction

Medication Allergies: _____

_____

Food Allergies and/or Intolerances: _____

_____

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

_____

AUTHORIZATION, 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 below. 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 the person in question. 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 will be used as primary coverage in the event medical intervention is needed. I further understand that I will be responsible for expenses not covered by my insurance.

I understand all reasonable safety precautions will be taken at all times by Camp Transfiguration 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, Camp Transfiguration, its leaders, employees, and/or volunteers liable for damages, losses, disease, or injuries incurred by the subject of this form.

I agree to abide by all the rules and guidelines set forth by Camp Transfiguration for the safety and good health of the campers and staff 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, Camp Transfiguration, 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 hereby agree to indemnify and hold harmless Camp Transfiguration, the Antiochian Orthodox Christian Archdiocese, their clergy, officers, directors, employees, staff and volunteers from any and all expenses, claims, costs or attorney fees incurred as a result of claims, actions and/or suits brought by me or by anyone else as a result of any accident of injury occurring to me.

I agree to participate in all camp activities, except the following (please list reason for each activity denied):

Activity	Reason for Denial of Permission
_____	_____
_____	_____

_____

Name (print) *Signature* *Date*

SCREENING RECORD – FOR CAMP USE ONLY

Date Screened: _____ Time: _____ Screened by: _____

Meds Received: _____

_____

Updates/additions to health history noted: ☐ Yes ☐ No ☐ None required

Current health needs identified: _____