



# 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.

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

Medicare Card #: \_\_\_\_\_

Carrier/Plan Name: \_\_\_\_\_

Group #: \_\_\_\_\_

ID #: \_\_\_\_\_

### GENERAL QUESTIONS

<i>Has/does the participant:</i>	Yes	No		Yes	No
1. Had any recent injury, illness, or disease?.....	<input type="checkbox"/>	<input type="checkbox"/>	20. Have an orthodontic appliance		
2. Have a chronic or recurring illness/condition? ...	<input type="checkbox"/>	<input type="checkbox"/>	being brought to camp? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	21. Have any skin problems		
4. Ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	(i.e., itching, rash, acne)?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>	22. Have diabetes?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?.....	<input type="checkbox"/>	<input type="checkbox"/>	23. Have asthma?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>	24. Had mononucleosis in the past year?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?..	<input type="checkbox"/>	<input type="checkbox"/>	25. Had problems with diarrhea/constipation?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?.....	<input type="checkbox"/>	<input type="checkbox"/>	26. Ever had an eating disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	27. If female, have an abnormal		
11. Ever been dizzy during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	menstrual history?.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had motion sickness?.....	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties	<input type="checkbox"/>	<input type="checkbox"/>
13. Been known to have nightmares?.....	<input type="checkbox"/>	<input type="checkbox"/>	for which professional help was sought?.....	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had seizures?.....	<input type="checkbox"/>	<input type="checkbox"/>	29. Ever had bleeding disorders?.....	<input type="checkbox"/>	<input type="checkbox"/>
15. Ever had chest pain during or after exercise?...	<input type="checkbox"/>	<input type="checkbox"/>	30. Have fainting spells?.....	<input type="checkbox"/>	<input type="checkbox"/>
16. Ever had high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>	31. Have chronic cramps?.....	<input type="checkbox"/>	<input type="checkbox"/>
17. Ever been diagnosed with a heart murmur?.....	<input type="checkbox"/>	<input type="checkbox"/>	32. Ever had convulsions?.....	<input type="checkbox"/>	<input type="checkbox"/>
18. Ever had back problems?.....	<input type="checkbox"/>	<input type="checkbox"/>	33. Have HIV?.....	<input type="checkbox"/>	<input type="checkbox"/>
19. Ever had joint problems (i.e., knees, ankles)?...	<input type="checkbox"/>	<input type="checkbox"/>	34. Ever had a hernia?.....	<input type="checkbox"/>	<input type="checkbox"/>

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

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### 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?

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

<input type="checkbox"/> Measles	Diphtheria/Tetanus/Pertussis/Polio (DTaP-IPV)...	_____
<input type="checkbox"/> Chicken Pox		
<input type="checkbox"/> Rubella (German Measles)	Tetanus/Diphtheria (Tdap).....	_____
<input type="checkbox"/> Mumps	Tetanus booster (Td).....	_____
<input type="checkbox"/> Hepatitis A		
<input type="checkbox"/> Hepatitis B	Pneumococcus.....	_____
<input type="checkbox"/> Hepatitis C	MMR.....	_____
<u>TB Mantoux Test (aka PPD):</u>	Meningococcus.....	_____
Date of last test: _____	Haemophilus influenzae B (HIB).....	_____
Result: <input type="checkbox"/> Positive	Hepatitis B.....	_____
<input type="checkbox"/> Negative	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: \_\_\_\_\_