



St. Vladimir's Camp
Please copy for each
camper

Form must be received by
June 20th,
 Please make a copy of this form to
 keep on file for your own reference.

2795 Wakefield Creek Road,
 Farmdale, OH 44117
 Phone: 330-583-2521
 Email: ohiodistrictcamp@cox.net

For Camp Use Only
 Cabin # _____

Health History and Examination Form

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. The health history portion must be filled out by parents/guardians of minors or by adults themselves. Additionally, a medical exam is required within 12 months of the camping session. If an exam was already done in that time period, your physician may be willing to fill out the form without an additional examination. The medical exam form on the last page must be completed and signed by approved licensed medical personnel.

Name: _____ Attending which session of camp: _____
Last First MI

Age while attending camp: _____ Date of Birth: _____ Gender: Male Female

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

Custodial parent/guardian(s):

Name _____ Phone: (h) _____ (w) _____ (cell) _____

Name _____ Phone: (h) _____ (w) _____ (cell) _____

Other Emergency Contact Name: _____ Home Phone: _____

Relationship to Camper : _____ 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)

A photocopy of the front and back of your health insurance card must be attached to this form.

Yes Carrier or plan name: _____

Group #: _____ I.D. #: _____

Insurance Holder's Name: _____ Date of Birth: _____

No

Health History & Information

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival to camp. Please provide complete information so that the camp can be aware of your health needs.

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) _____

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.)

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
Dimetapp Products	Yes	No	Cough Lozenges	Yes	No	Sterile Eye Irrigate	Yes	No
Mucinex Products	Yes	No	External Ointments,	Yes	No	Sudafed	Yes	No
Benadryl	Yes	No	Sprays, Lotions					

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		
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)

OTHER CAMPER INFORMATION

We want your camper to have the best possible experience while at St. Vladimir's Camp. All information is regarded as STRICTLY CONFIDENTIAL and will only be shared with staff who work with your camper and other necessary personnel (Camp Director, Nurse, Food Service Director, etc.) as appropriate.

•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 provide 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 St. Vladimir's Camp.

•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

•Dietary restrictions: None Vegetarian Vegan Diabetic Other: _____

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 child 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 pre-scribed 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 expenses not covered by my insurance.

I understand all reasonable safety precautions will be taken at all times by the St. Vladimir's Camp 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 OCA, St. Vladimir's Camp, its leaders, employees, and/or volunteers liable for damages, losses, disease, 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 St. Vladimir's 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 OCA, St. Vladimir's Camp, 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 St. Vladimir's Camp, the OCA, 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, my child or on my behalf or on my child's behalf or by anyone else as a result of any accident of injury occurring to me or my child.

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

Activity	Reason for Denial of Permission
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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*

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 (including food): _____

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: _____

For camp use only

SCREENING RECORD

Date screened _____ Time _____ Screened by _____

Meds Received _____

Updates/additions to health history noted Yes No None required

Current health needs identified _____