# St. Sava Camp
# Shadeland

25072 State Highway 18, Springboro, PA 16435
Phone/Fax: (814) 587-2627

# 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 page 3 must be completed and signed by approved licensed medical personnel.

Name: _____ Birthdate: _____
Last First MI M/D/Y

Age while attending camp: _____ Gender: __ Male __ Female

Home Address: _____

Street Address _____ City _____ State/Prov. Zip _____

Custodial parent/guardian(s): _____ HomePhone: _____
Other Phone: _____
_____ HomePhone: _____
Other Phone: _____

Other Emergency Contact Name: _____ Home Phone: _____

Name of family physician _____ Phone: _____
Name of family dentist/orthodonist _____ 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. #: _____
☐ 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/Acetaminophen | Yes | No | Pepto Bismol | Yes | No | Antacids | Yes | No |
| Cough Syrup | Yes | No | Antiseptic Throat Spray | Yes | No | Benadryl | Yes | No |
| Advil/Ibuprofen | Yes | No | Cough Lozenges | Yes | No | Sterile Eye Irrigate | Yes | No |
| Sudafed | Yes | No | External Ointments, Sprays, Lotions | Yes | No | | | |

**GENERAL QUESTIONS** (Please explain any "yes" answers in space provided on the last page of the health form.)

| 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 menstural history? . | ? | ? |
| 26. Ever had emotional difficulties for which professional help was sought? ..... | ? | ? |

## 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: _____

## **IMPORTANT — THESE BOXES MUST BE COMPLETE FOR ATTENDANCE**

**This health history is correct and complete as far as I know. The person herein named has permission to engage in all camp activities except as noted.**

**I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and over the counter medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.**

**It is my intention that the camp be treated as acting in loco parentis if the person herein names is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR §164.510 (b) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.**

**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. This completed form may be photocopied for trips out of camp.**

**Signature of parent or guardian or adult camper/staffer** _____

**Printed Name** _____ **Date** _____

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

**Signature of minor or adult camper/staffer** _____ **Date** _____

## OTHER CAMPER INFORMATION

We want your camper to have the best possible experience while at St. Sava Camp/Shadeland. 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: (check one) 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 the St. Sava Camp/Shadeland.

·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

_____

_____

_____

_____

_____

_____

_____

_____

_____

For camp use only

Meds Received by: _____

_____