



# Camp St. George

PO Box 6515, Madison, WI 53716  
Fr. Patrick Kinder, Camp Director  
www.campstgeorge.org

## 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 24 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: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Last First MI

Age while attending camp: \_\_\_\_\_ Gender:  Male  Female

Home Address: \_\_\_\_\_  
Street Address City State Zip

Custodial parents/guardians: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 \_\_\_\_\_ Other Phone: \_\_\_\_\_  
 \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 \_\_\_\_\_ Other Phone: \_\_\_\_\_

Other 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)*  
**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 Any costs incurred by Camp St. George in providing necessary medical treatment will be the responsibility of the parents/legal guardians. Please initial: \_\_\_\_\_

## Health History & Information

The following information must be completed by the parent/guardian for campers under 18 or by campers or staff members over 18. 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 care personnel prior to arrival at camp. Please provide complete information so that the camp can be aware of your health needs.

Which of the following has the participant had?	<b><u>PLEASE GIVE DATES OF IMMUNIZATION FOR:</u></b>
<input type="checkbox"/> Measles	DTP _____
<input type="checkbox"/> Chicken Pox	TD (tetanus/diphtheria) _____
<input type="checkbox"/> German measles	Tetanus _____
<input type="checkbox"/> Mumps	Polio _____
<input type="checkbox"/> Hepatitis A	MMR _____
<input type="checkbox"/> Hepatitis B	or Measles _____
<input type="checkbox"/> Hepatitis C	or Mumps _____
	or Rubella _____
TB Mantoux Test	Haemophilus influenza B _____
Date of last test _____	Hepatitis B _____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Varicella (chicken pox) _____
	Other _____

**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	Yes	No	Pepto Bismol	Yes	No	Antacids	Yes	No
Advil	Yes	No	Cough Syrup	Yes	No	Cough Lozenges	Yes	No
Benadryl	Yes	No	Sterile Eye Irrigate	Yes	No	External Ointments, Sprays, Lotions	Yes	No

**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 (i.e., knees, ankles)?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?...	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (i.e., itching, rash, acne)?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?.....	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past year?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?.....	<input type="checkbox"/>	<input type="checkbox"/>	24. Ever had an eating disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?.....	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	26. Ever had emotional difficulties for which professional help was sought?....	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>			
12. Ever had seizures?.....	<input type="checkbox"/>	<input type="checkbox"/>			
13. Ever had chest pain during or after exercise?...	<input type="checkbox"/>	<input type="checkbox"/>			
14. Ever had high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?.....	<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)

\_\_\_\_\_

**Any other concerns staff needs to be aware of , i.e. bedwetting, fear of dark, stress in family, etc?** \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

IMPORTANT: Any additional information for health care staff at the camp (recent med changes, emotional disruptions, etc):

\_\_\_\_\_

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:** \_\_\_\_\_

Name Printed: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## AUTHORIZATION, PERMISSIONS AND AGREEMENT

This health history is correct and complete to the best of my knowledge. The person named herein 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. In the event that 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. I understand that my insurance coverage will be used as primary coverage in the event that medical treatment is needed. I further understand that I will be responsible for any medical expenses not covered by my insurance.

I understand all reasonable safety precautions will be taken at all times by Camp St. George 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 St. George, YMCA Camp Wapsie, their leaders, employees, and/or volunteer staff liable for damages, losses, diseases or injuries incurred while at camp.

I agree that the person named herein will abide by all the rules and guidelines set forth by Camp St. George for the safety and good health of all the campers and staff. I also understand that if the person named herein is sent 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 St. George, Camp Wapsie, 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 trips out of camp.

I give permission for the person named herein to participate in all camp activities, with the exception of the following (please list reason for each activity denied):

Activity	Reason for Denial of Permission
_____	_____
_____	_____

**Signature of parent/guardian or adult camper/staff:**

\_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*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 \_\_\_\_\_  
\_\_\_\_\_