Camp St. George

3650 Cottage Grove AV SE
Cedar Rapids Iowa 52403
Fr Fred Shaheen, Camp Director
www.campstgeorge.org

Staff/Counselor Health History and Examination Form

The following information must be filled in by the staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Additionally, a medical exam is required within 24 months of the camping session. If an exam has been done during this time period, you may submit a letter signed by your physician's office in place of the examination form attached. Any changes to this form should be provided to camp health personnel prior to arrival at Staff Training. Please provide complete information so that the Camp Director and health care personnel are aware of your health needs.

Name: _____ Birthdate: _____
First MI Last

Gender: □ Male □ Female

Home Address: _____
Street Address City State Zip

Home Phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Home Phone: _____

Cell Phone: _____

Name of physician: _____ Phone: _____

Name of dentist: _____ Phone: _____

Are you covered by 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 your responsibility.
Please initial: _____

Which of the following have you had?
□ Measles □ Chicken Pox □ German measles □ Mumps □ Hepatitis A
□ Hepatitis B □ Hepatitis C □ TB Mantoux Test: Date of last test____Result: □ Positive□ Negative

Are your immunizations current/up to date? □ Yes □ No Tetanus Immunization (date/year if possible): _____

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.

GENERAL QUESTIONS (Explain "yes" answers below.)

Have you/Do you:	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		□
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		□
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 menstrual history?……. □		□
26. Ever had emotional difficulties for which professional help was sought?….		□

Please explain any "yes" answers, noting the number of the questions. (use additional pages if necessary)

Are there any other concerns the Camp Director or health care personnel should be made aware of , whether physical/mental/ emotional and including stress-related situations regarding family or other relationships?

AUTHORIZATIONS, PERMISSIONS AND AGREEMENT

This health history is correct and complete as far as I know. 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 re- lated transportation if necessary. In the event of 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 medical intervention is needed. I further understand that I will be responsible for expenses not covered by my insurance. I understand that 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 or Camp St. George employees or volunteers liable for damages, losses, disease, or injuries incurred while at staff training and at camp.

I agree to abide by all the rules and guidelines set forth by Camp St. George for the safety and good health of the campers and staff. I agree to indemnify and hold harmless the Antiochian Orthodox Christian Archdiocese, Camp St. George, 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.

Signature_____ Date _____

Printed Name _____

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: _____