

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.)

	Yes	No		Yes	No
Has/does the participant:					
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 Camp St. Thekla. 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.

What is your child looking forward to at camp? _____

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 Camp St. Thekla.

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

Swimming ability: Cannot Swim* Beginner Intermediate Expert

* I give permission for the camp to administer swim lessons, should they be available during camp.

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 person 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 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 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 Camp St. Thekla 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. Thekla, 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 Camp St. Thekla 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 Antiochian Orthodox Christian Archdiocese, Camp St. Thekla, 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 hereby agree to indemnify and hold harmless Camp St. Thekla, 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, 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
_____	_____
_____	_____

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: _____

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: _____

Phone: _____ Fax: _____

For camp use only:

SCREENING RECORD
Date screened: _____ Time: _____ Screened by: _____
Meds Received: _____ _____
Updates/additions to health history noted <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None required
Current health needs identified: _____ _____