CAMP NAZARETH

Retreat and Conference Center

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HEALTH HISTORY FORM

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist in identifying appropriate care. The Health History must be completed by the parents/guardians of minors or by adults themselves. Additionally, a medical exam (i.e. a physical) is required within 12 months of the camping session. Please see the separate Medical Examination Form which must be completed and signed by an approved, licensed medical professional (licensed physician or physician's assistant). Please be sure this entire form is complete. This form follows the most recent standards of the ACA and is a necessary part of the application process. Thank you for your cooperation.

NAME: ____

Last *First* *Middle*

BIRTH DATE: _____/_____/_____ AGE: ________ SOCIAL SECURITY #: ______-_____-______ GENDER: ❑ M ❑ F

HOME ADDRESS: ____

Street Address *City* *State* *Zip*

CUSTODIAL PARENT/GUARDIAN: ____

HOME PHONE: ____________________ WORK PHONE: ____________________ CELL PHONE: ____________________

SECONDARY PARENT/GUARDIAN/EMERGENCY CONTACT: ____

HOME PHONE: ____________________ WORK PHONE: ____________________ CELL PHONE: ____________________

IF NEITHER ARE AVAILABLE, PLEASE CONTACT: ____

RELATIONSHIP: ____________________ HOME PHONE: ____________________ CELL PHONE: ____________________

INSURANCE INFORMATION: Is the participant covered by family medical/hospital insurance? ❑ Yes ❑ No
If so, indicate carrier or plan name:____________________ Policy #:____________________ Group #: ____________________
Who holds the policy the camper is covered by (father, mother, or indicate other):____________________

THE FOLLOWING MUST BE COMPLETE FOR ATTENDANCE

This health history is correct and complete as far as I know. I am able 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 including testing related to diagnosing Covid-19 for me. 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. In the event that I am unable to communicate effectively in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment including hospitalization, for myself. 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 any expenses not covered by my insurance. I understand all reasonable safety precautions will be taken at all times by Camp Nazareth and its agents during camp. I understand the possibility of unforeseen hazards and know the inherent possibility of risk, including risks related to the novel Coronavirus (Covid-19). I agree not to hold the Carpatho-Russian Orthodox Diocese in North America, Camp Nazareth, their leaders, employees, and/or volunteer staff liable for damages, losses, diseases, or injuries incurred by the subject of this form. I agree to abide by all of the rules and guidelines set forth by Camp Nazareth for the order, safety, and good health of the campers/staffers/volunteers at camp. I agree to indemnify and hold harmless, the Carpatho-Russian Orthodox Diocese in North America, Camp Nazareth, 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 also understand and agree to abide by any restrictions placed on my participation in camp activities and will comply with all of the reasonable requests made by the Camp Nazareth Administration in regards to order, safety, and good health.

Signature of Staff Member: ____

Print Name: ____ Date: ____________________

Health History

The parent, guardian, adult camper or staff member **must** fill in the following information. The intent of this information is to provide the Camp health care personnel the necessary background information to provide appropriate care. Keep a copy of the completed form for your records if you wish. Any changes to this form should be provided to the Camp health care personnel upon the participant's arrival at the Camp. Provide complete information so that the Camp can be made aware of your needs.

ALLERGIES | **Describe reaction and management of reaction**

______________________________ ____
______________________________ ____
______________________________ ____
______________________________ ____

FOOD ALLERGIES

______________________________ ____
______________________________ ____
______________________________ ____
______________________________ ____

OTHER ALLERGIES

______________________________ ____
______________________________ ____
______________________________ ____
______________________________ ____

MEDICATIONS CURRENTLY BEING TAKEN

Please list **ALL** medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. ALL medications must be turned over to the Camp medical personnel upon arrival, no exceptions. If your child must have any medications (prescription and non-prescription included) on his/her person, this **must** be acknowledged by the medical personnel, in writing, on the final page.

Please check here to indicate if the person being represented by this form takes no medications whatsoever: ☐

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 Page if Necessary.
Identify any medications taken normally or during the school year that the participant does/may not take during summer and why:
____

RESTRICTIONS
Please list here any restrictions to activities that are medically necessary (I.e. what cannot be done, what adaptations or limitations are necessary).
____
____
____

OVER-THE-COUNTER MEDICINES:
Please circle Yes or No to each over–the-counter medication that your child is permitted to take while at Camp Nazareth:

Aspirin	- Yes No	Pepto Bismol	- Yes No	Antacids	- Yes No
Tylenol	- Yes No	Cough Syrup	- Yes No	Antiseptic Throat Spray	- Yes No
Advil	- Yes No	Cough Lozenges	- Yes No	Sterile Eye Irrigate	- Yes No
Benadryl	- Yes No	External Ointments Sprays, or Lotions	- Yes No	Sudafed	- Yes No

Please list any other over-the-counter medicines that you specifically do not want administered, if any exist:
____
____

GENERAL QUESTIONS: (Explain "Yes" answers below)

Has/Does the participant have?

1. Had any recent injury, illness, or disease? Yes No
2. Have a chronic or recurring illness/condition? Yes No
3. Ever been hospitalized? Yes No
4. Ever had surgery? Yes No
5. Have frequent headaches? Yes No
6. Ever had a head injury? Yes No
7. Ever been knocked unconscious? Yes No
8. Wear glasses, contacts, or protective eyewear? Yes No
9. Ever had frequent ear infections? Yes No
10. Ever passed out during or after exercise? Yes No
11. Ever been dizzy during or after exercise? Yes No
12. Ever had seizures? Yes No
13. Ever had chest pain during or after exercise? Yes No
14. Ever had high blood pressure? Yes No
15. Ever been diagnosed with a heart murmur? Yes No
16. Ever had back problems? Yes No
17. Ever had joint problems (i.e. knees, ankles, etc.)? Yes No
18. Have an Orthodontic appliance being brought to camp? Yes No
19. Have any skin problems? (itching, rash, acne, etc.)? Yes No
20. Have Diabetes? Yes No
21. Have Asthma? Yes No
22. Had mononucleosis in the past year? Yes No
23. Had problems w/diarrhea/constipation? Yes No
24. Ever had an eating disorder? Yes No
25. If female, have an abnormal menstrual history? Yes No
26. Ever had emotional difficulties for which professional help was sought? Yes No
27. Tested positive for COVID-19? Yes No
    (If yes, date of positive test__________. Please attach Positive result documentation.)

Please explain any "Yes" answers, noting the number of the question. (Use additional pages if necessary)

____

____

Has the participant had or do they have any of the following: cancer, chronic kidney disease, COPD (chronic obstructive pulmonary disease), heart conditions (such as heart failure, coronary artery disease, or cardiomyopathies), immunocompromised state (weakened immune system) from solid organ transplant, obesity (body mass index [BMI] of 30 kg/m2 or higher but <40 kg/m2), severe obesity (BMI>=40 kg/m2), sickle cell disease, smoking? Please list any of the above conditions AND any others that would put the participant at higher risk for severe illness related to COVID-19 (attach additional pages if necessary):

____

____

Which of the following (illnesses) has the participant had?

- ❑ Measles
- ❑ Chicken Pox
- ❑ German Measles
- ❑ Mumps
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Covid 19

TB Mantoux Test
Date of last test __________
Result: ❑ Positive ❑ Negative

PLEASE GIVE ALL DATES OF IMMUNIZATION FOR:

DTP ____________________
TD (Tetanus/Diphtheria) ____________________
Tetanus ____________________
Polio ____________________
MMR ____________________
or Measles ____________________
or Mumps ____________________
or Rubella ____________________
Haemophilus Influenza B ____________________
Hepatitis B ____________________
Varicella ____________________
COVID-19 ____________________

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware. Attach additional pages if necessary.

____

____

Name of family physician: ____________________________ Phone: ________________

Address: ____

Name of family Dentist/Orthodontist: ______________________ Phone: ________________

Address: ____