



# CAMP NAZARETH

Retreat and Conference Center

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## 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 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 form on the last page must be completed and signed by an approved, licensed medical professional. Please be sure this entire form is complete. This form follows the strictest codes 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. 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 for me/my child. I understand that the Camp Nazareth Administrator reserves the right to inspect cabins and/or the personal belongings of a camper, when it is reasonably believed a participant may be harboring forbidden, banned, or illegal materials. 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 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. I agree not to hold the American Carpatho-Russian Orthodox Diocese, 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 that my child will abide by all of the rules and guidelines set forth by Camp Nazareth for the order, safety, and good health of the campers at camp. I give permission for my child to participate in all camp activities. 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 American Carpatho-Russian Orthodox Diocese, Camp Nazareth, 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 emergency trips out of camp.

Signature of parent or guardian or adult camper/staffer: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

I, the camper signed below, also understand and agree to abide by any restrictions placed on my participation in camp activities and/or will comply with all of the reasonable requests made by the Camp Nazareth Staff in regards to my participation, safety, and good health.  
(Camper must sign below so as to acknowledge that they understand the above)

Signature of **minor camper**: \_\_\_\_\_ 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 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	- Yes	No	Sudafed	- Yes	No
			Sprays, or Lotions					

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 | 17. Ever had joint problems (i.e. knees, ankles, etc.)?                     | Yes | No |
| 2. Have a chronic or recurring illness/condition? | Yes | No | 18. Have an Orthodontic appliance being brought to camp?                    | Yes | No |
| 3. Ever been hospitalized?                        | Yes | No | 19. Have any skin problems? (itching, rash, acne, etc.)?                    | Yes | No |
| 4. Ever had surgery?                              | Yes | No | 20. Have Diabetes?  | Yes | No |
| 5. Have frequent headaches?                       | Yes | No | 21. Have Asthma?  | Yes | No |
| 6. Ever had a head injury?                        | Yes | No | 22. Had mononucleosis in the past year?                                     | Yes | No |
| 7. Ever been knocked unconscious?                 | Yes | No | 23. Had problems w/diarrhea/constipation?                                   | Yes | No |
| 8. Wear glasses, contacts, or protective eyewear? | Yes | No | 24. Ever had an eating disorder?  | Yes | No |
| 9. Ever had frequent ear infections?              | Yes | No | 25. If female, have an abnormal menstrual history?                          | Yes | No |
| 10. Ever passed out during or after exercise?     | Yes | No | 26. Ever had emotional difficulties for which professional help was sought? | 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 |   |     |    |

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

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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 ALL DATES OF IMMUNIZATION FOR:**

- DTP \_\_\_\_\_
- TD (Tetanus/Diphtheria) \_\_\_\_\_
- Tetanus \_\_\_\_\_
- Polio \_\_\_\_\_
- MMR \_\_\_\_\_
- or Measles \_\_\_\_\_
- or Mumps \_\_\_\_\_
- or Rubella \_\_\_\_\_
- Haemophilus Influenza B \_\_\_\_\_
- Hepatitis B \_\_\_\_\_
- Varicella \_\_\_\_\_

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.

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Name of family physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Name of family Dentist/Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

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

# HEALTH HISTORY RECOMMENDATIONS

To be filled out and signed by a **Licensed Medical Professional**

I examined \_\_\_\_\_ this individual on the date of \_\_\_\_\_

*Name of Potential Camper/Applicant*

*Date of Examination*

(Camp Nazareth requires an **ANNUAL EXAMINATION**, as allowed by the ACA. This exam is **required** for camp attendance. If the camper or staffer has received a physical exam within the last year, another exam is not required, however, this form **must still be filled out and signed by the Medical professional who had performed that physical.**)

Blood Pressure: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

In my opinion, the above applicant  is or  is not able to participate in this summer's active camp program.

The applicant is under the care of a physician for the following conditions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Recommendations and Restrictions at Camp

Treatment to be continued at camp: \_\_\_\_\_

\_\_\_\_\_

Medications to be administered at camp (name, dosage, frequency): \_\_\_\_\_

\_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_

**Signature of Licensed Medical Professional:** \_\_\_\_\_

Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

*The section below is for Camp Personnel uses only, please disregard:*

Screening Record at Check-In

Date Screened: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

Medications received (Prescription and non-prescription): \_\_\_\_\_

\_\_\_\_\_

Updates/additions to health history?  Yes  No If yes, \_\_\_\_\_

\_\_\_\_\_

Current health needs identified? \_\_\_\_\_

\_\_\_\_\_

Observational notes: \_\_\_\_\_

\_\_\_\_\_

Screened by: \_\_\_\_\_