



METROPOLIS OF DENVER

CAMP EMMANUEL 2009

GREEK ORTHODOX METROPOLIS OF DENVER

4550 E. ALAMEDA AVE. DENVER, CO 80246 · TEL.: (303) 333-7794 · FAX: (303) 333-7796
 WEB: WWW.DENVER.GOARCH.ORG ·

CAMPER HEALTH RECORD FORM

Original must be mailed. Please keep a copy for your records.

OFFICE
USE
ONLY

CABIN NAME

NAME
NOTES

Pages 1– 3 are to be completed by parent/guardian. The form, in its entirety must be reviewed, completed, and signed by the health care provider. This form is used to help camp medical staff in determining appropriate care. This information is confidential and will be shared only on a “need to know” basis with Camp Staff.

EMERGENCY CONTACT INFORMATION

Camper Name _____

Home Address _____ Phone _____

Birth Date _____ Age _____ Gender _____

Parent/Guardian Name _____ Phone _____

Home Address _____ Mobile _____

Other Parent/Guardian Name _____ Phone _____

Home Address _____ Mobile _____

If parent and other parent/guardian are not available in an emergency, please notify:

Name _____ Relationship _____

Address _____ Phone _____

IMMUNIZATION HISTORY (Provide the month and year for each immunization. Starred (*) MUST be current.

Copies from health-care providers are acceptable (please attach to this form).

Diphtheria, tetanus, pertussis* _____	Hepatitis B _____
Tetanus booster* _____	Hepatitis A _____
Mumps, measles, rubella* _____	Varicella (chicken pox) _____
Polio* _____	Menigococcal meningitis _____
Haemophilus infleuzae type B _____	Tuberculosis (tb) test _____
Pneumococcal _____	

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

Signature of parent/guardian: _____ **Date:** _____

CAMPER HEALTH RECORD FORM

INSURANCE INFORMATION

Does the participant have family medical/hospital insurance? Yes No

Carrier _____ Policy or Group # _____ Insurance Company Phone # _____

Name of Policy Holder _____ Relation to Participant _____

SS # of Policy Holder or Insurance ID Number _____

A copy of the Insurance Card
must be stapled here.

Front of Card

A copy of the Insurance Card
must be stapled here.

Back of Card

IMPORTANT— PLEASE READ CAREFULLY AND SIGN

Parent or Guardian Consent: This health history is correct and complete to my knowledge. The person described has permission to participate in all camp activities except as noted. I give permission to photocopy this form. I hereby give permission to the camp to obtain relevant health care, 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 insurance purposes. I give permission for the camp to arrange related transportation for my child. The purpose of onsite camp medical staff is solely for administering medications and performing triage and minor first-aid. In the event that I cannot be reached in an emergency, I hereby give permission to the health care provider selected by the camp to secure and administer treatment, including hospitalization.

Parents/guardians are responsible for ALL medical bills incurred while at camp (doctor visits, emergency room visits, and prescriptions). All attempts will be made to contact parent/guardian before taking the camper for "off camp medical care." A description of care received will be given to the parent.

Signature of Custodial Parent/Guardian: _____

Witness: _____ **Date:** _____

MENTAL, EMOTIONAL, AND SOCIAL HEALTH: Check "Yes" or "No" for each statement.

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD) Yes No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? Yes No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? Yes No
4. Had a significant life event that continues to affect the camper's life? Yes No

(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

CAMPER HEALTH RECORD FORM

GENERAL HEALTH HISTORY Participant has or has had any of the following: (Please check if YES.)

- | | |
|---|--|
| 1. Recent injury, illness, infection _____ | 13. Joint problems _____ |
| 2. Chronic illness/condition _____ | 14. Back problems _____ |
| 3. Surgery _____ | 15. Skin problems (i.e. rash, acne) _____ |
| 4. Frequent headaches/migraines _____ | 16. Mononucleosis in the last 6 months _____ |
| 5. Recent head injury _____ | 17. Asthma _____ |
| 6. Heart murmur _____ | 18. Diarrhea/constipation _____ |
| 7. Diabetes _____ | 19. Sleepwalking _____ |
| 8. Glasses, contacts _____ | 20. Orthodontic appliances _____ |
| 9. Frequent ear infections _____ | 21. Significant emotional difficulties _____ |
| 10. Passed out during or after exercise _____ | 22. Bed-wetting _____ |
| 11. Dizzy during or after exercise _____ | 23. Eating disorder _____ |
| 12. High blood pressure _____ | 24. Other _____ |

Please explain any "yes" answers:

IF FEMALE (Please answer YES or NO.)

Has this person menstruated? _____ If not, has she been educated about it? _____ Is her menstrual history normal? _____

ALLERGIES (list all known) Describe the reaction and management of the reaction.

Medication Allergies (list) _____

Food Allergies (list) - (i.e. Nuts, lactose intolerance, shellfish, etc.) _____

Other Allergies (list) - (i.e. insect stings, hay fever, asthma, animal, plant, etc.) _____

MEDICATIONS BEING TAKEN Please list all prescription and non-prescription medications taken on a regular basis. Please keep in original bottles labeled with health care provider's name, phone number, dosage and instructions. **Place all medicines in one plastic Ziploc bag and label with camper's name.**

Please attach additional pages for more medications. Make sure to notify the medical staff when you arrive at camp if additional medications have been added after the health form was filled out.

1) Med _____ Dosage _____ Specific times per day _____
Reason for taking _____

2) Med _____ Dosage _____ Specific times per day _____
Reason for taking _____

3) Med _____ Dosage _____ Specific times per day _____
Reason for taking _____

The following non-prescription medications may be given to my child, if needed: (Please circle YES or NO)

Tylenol/acetaminophen	YES	NO	Decongestant	YES	NO
Advil/ibuprofen	YES	NO	Benadryl	YES	NO
Cough syrup, lozenges, throat spray	YES	NO	External ointments, sprays, lotions	YES	NO
Antacid	YES	NO	Pepto Bismol	YES	NO
Imodium	YES	NO	Other medications per discretion of camp medical staff	YES	NO

CAMPER HEALTH RECORD FORM

TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER

I examined this individual on _____ (Exam must be performed within 12 months of camp attendance.)

BP _____ Weight _____ Height _____

RECOMENDATIONS AND RESTRICTIONS Explain what limitations are necessary.

Dietary (i.e. vegetarian): no restriction restriction: _____

Physical Activity: no restriction restriction: _____

Swimming/Diving: no restriction restrition: _____
(Is capable of swimming the deep end of the pool?) yes no uncertain (Certified lifeguard will evaluate.)

Other restrictions:

Signature of Licensed Health Care Provider _____

Name (printed) _____ Title _____

Address _____

Phone _____ Date _____

CAMP SCREENING/TREATMENT RECORD (CAMP USE ONLY)

Needs Identified/Actions Taken/Medications Administered (date, time, and initial all entries):

Additional Provider Notes:

Provider Signature: _____ Date: _____