



1663 Tutwiler Ave, Memphis, TN 38107

Phone: 901.274.4119

Email: [CampStThekla@gmail.com](mailto:CampStThekla@gmail.com) Website: [www.CampStThekla.org](http://www.CampStThekla.org)



## 2017 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 us in identifying appropriate care. The health history portion **must be filled out by parents/guardians of minors** or by adults themselves. **Return by June 1.**

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Last First MI

Age while attending camp: \_\_\_\_\_ Gender:  Male  Female

Home Address: \_\_\_\_\_  
Street Address City State/Prov. Zip

Custodial parent/guardian(s):  
 Name \_\_\_\_\_ Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (cell) \_\_\_\_\_  
 Name \_\_\_\_\_ Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (cell) \_\_\_\_\_

Other Emergency Contact Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Relationship to Camper : \_\_\_\_\_ Other Phone: \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone: \_\_\_\_\_  
 Name of family dentist/orthodontist \_\_\_\_\_ Phone: \_\_\_\_\_

Is the participant covered by family 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. #: \_\_\_\_\_  
 Insurance Holder's Name: \_\_\_\_\_ Soc.Sec.# \_\_\_\_\_ Birthdate \_\_\_\_\_

No

## Health History & Information

The following information must be filled in by the parent/guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival to camp. Please provide complete information so that the camp can be aware of your health needs.

Which of the following has the participant had?	<b>PLEASE GIVE DATES OF IMMUNIZATION FOR:</b>
<input type="checkbox"/> Measles	DTP _____
<input type="checkbox"/> Chicken Pox	TD (tetanus/diphtheria) _____
<input type="checkbox"/> German measles	Tetanus _____
<input type="checkbox"/> Mumps	Polio _____
<input type="checkbox"/> Hepatitis A	MMR _____
<input type="checkbox"/> Hepatitis B	or Measles _____
<input type="checkbox"/> Hepatitis C	or Mumps _____
TB Mantoux Test	or Rubella _____
Date of last test _____	Haemophilus influenza B _____
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Hepatitis B _____
	Varicella (chicken pox) _____

**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.)

Has/does the participant:	Yes	No	Yes	No
1. Had any recent injury, illness, or disease?.....	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had joint problems (i.e., knees, ankles)?.....	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?...	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?.....	<input type="checkbox"/>
3. Ever been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (i.e., itching, rash, acne)?.....	<input type="checkbox"/>
4. Ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?.....	<input type="checkbox"/>
5. Have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?.....	<input type="checkbox"/>
6. Ever had a head injury?.....	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past year?.....	<input type="checkbox"/>
7. Ever been knocked unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?.....	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?.....	<input type="checkbox"/>	<input type="checkbox"/>	24. Ever had an eating disorder?.....	<input type="checkbox"/>
9. Ever had frequent ear infections?.....	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?.....	<input type="checkbox"/>
10. Ever passed out during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	26. Ever had emotional difficulties for which professional help was sought?....	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>		
12. Ever had seizures?.....	<input type="checkbox"/>	<input type="checkbox"/>		
13. Ever had chest pain during or after exercise?...	<input type="checkbox"/>	<input type="checkbox"/>		
14. Ever had high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>		
15. Ever been diagnosed with a heart murmur?.....	<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 participant's 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*