



# Health Form - Chapel Rock Summer Camps 2012

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. Health history (first three pages) must be filled out by parents/guardians of minors or by the adults themselves. Update required annually. Health exam (fourth page) to be completed by approved licensed medical personnel is optional but recommended at least every two years. **This form must be returned two weeks prior to your camp start date.**

Camper Name \_\_\_\_\_  
Last First

Home Address \_\_\_\_\_  
Street City State Zip

Birth date \_\_\_\_\_ Age at Camp \_\_\_\_\_ Grade (Spring 2011) \_\_\_\_\_ Gender  Male  Female

Church \_\_\_\_\_

**Custodial parent/guardian** \_\_\_\_\_ Home phone \_\_\_\_\_

Home address \_\_\_\_\_  
(if different from above) Street City State Zip

Business Phone \_\_\_\_\_ Cell phone/pager \_\_\_\_\_

**Second parent or guardian** \_\_\_\_\_ Home phone \_\_\_\_\_

Home address \_\_\_\_\_  
(if different from above) Street City State Zip

Business Phone \_\_\_\_\_ Cell phone/pager \_\_\_\_\_

**If not available, in an emergency, notify** \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone \_\_\_\_\_ Business phone \_\_\_\_\_ Cell phone/pager \_\_\_\_\_

## Important – These boxes must be completed for attendance\*

**Consent for Treatment:** The information given on this form is correct and complete as far as I know. The person here-in named has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me/my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the person named herein is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as “personal representatives” for the purpose of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person’s ability to participate in camp activities; and (ii) in the case of minors,

to provide relevant information to the camp representatives to keep me informed of my child’s health status.

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. This completed form may be photocopied for trips out of camp.

**Activity Disclosure:** Chapel Rock programs vary by age groups, but may involve a variety of activities that include warm-ups, games, group initiatives, and high and low ropes course elements. Activities may also include swimming, rock climbing, rappelling, kayaking, canoeing, and orienteering. All programs are conducted by trained professional staff, yet there is a risk that must be assumed by each participant. By signing below, I give my consent for my camper to participate in these activities, except as noted elsewhere on this form. I further consent that my child may be transported by school/commercial bus or van for off site camp activities. I understand that Chapel Rock and the Episcopal Diocese of Arizona assume no liability for accidental injury to my child during his/her stay at camp.

In the event of the withdrawal or dismissal from camp for any reason other than illness requiring the attention of a physician, I will pay the camp fee in full.

**Photo release:** May we use photos or videos of your camper for camp promotional materials?  Yes  No

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

Printed name \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Camper signature \_\_\_\_\_ Date \_\_\_\_\_

# Health History

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. Keep a copy of the completed form for your records.

Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

**ALLERGIES** List all known. Describe reaction and management of the reaction.

### Medication allergies (list)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Food allergies (list)

\_\_\_\_\_  
\_\_\_\_\_

**Other allergies (list)** – include insect stings, hay fever, asthma, animal dander, etc.

\_\_\_\_\_  
\_\_\_\_\_

### MEDICATIONS BEING TAKEN

Please list ALL medications (including over the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time of 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.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med # 1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
Reason for taking \_\_\_\_\_

Med # 2 \_\_\_\_\_ 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: \_\_\_\_\_  
\_\_\_\_\_

The following non-prescription medications may be administered under the direction of the camp nurse. Any medications you **DO NOT** want your camper to take, please **cross out**.

- |                     |                       |                            |                  |                  |
|---------------------|-----------------------|----------------------------|------------------|------------------|
| Antibiotic ointment | Benadryl cream        | Hydrocortisone cream       | Solarcaine spray | Caladryl lotion  |
| Sting kill swabs    | Pepto Bismol          | Ibuprofen                  | Acetaminophen    | Benadryl capsule |
| Sudafed             | Tussin DM cough syrup | Sore throat lozenges/spray | Kaopectate       | Milk of Magnesia |

### RESTRICTIONS

The following restrictions apply to this individual:

#### Dietary

- Does not eat red meat       Does not eat pork       Does not eat eggs       Does not eat poultry
- Does not eat seafood       Does not eat dairy products
- Other (describe) \_\_\_\_\_

**Explain any restrictions to activity** (e.g., what cannot be done, what adaptations or limitations are necessary, swimming ability) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**GENERAL QUESTIONS** (Explain “yes” answers below)

|  |                          |                          |   |                          |                          |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Has/does the participant:                                    | <b>Yes</b>               | <b>No</b>                |   | <b>Yes</b>               | <b>No</b>                |
| 1. Had a recent injury, illness, or infectious disease?..... | <input type="checkbox"/> | <input type="checkbox"/> | 16. Ever had joint problems (e.g., knees, ankles)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition?.....       | <input type="checkbox"/> | <input type="checkbox"/> | 17. Have an orthodontic appliance?.....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized?.....                              | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have any skin problems (e.g., itching, rash, acne)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery?.....                                    | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have diabetes?.....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches?.....                             | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have asthma?.....                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury?.....                              | <input type="checkbox"/> | <input type="checkbox"/> | 21. Had mononucleosis in the past 12 months?.....       | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious? .....                      | <input type="checkbox"/> | <input type="checkbox"/> | 22. Had problems with diarrhea/constipation?.....       | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts or protective eyewear?.....        | <input type="checkbox"/> | <input type="checkbox"/> | 23. Have problems with sleepwalking?.....               | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had frequent ear infections? .....                   | <input type="checkbox"/> | <input type="checkbox"/> | 24. If female, have an abnormal menstrual history?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed out during or after exercise?.....           | <input type="checkbox"/> | <input type="checkbox"/> | 25. Have a history of bed-wetting?.....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been dizzy during or after exercise?.....           | <input type="checkbox"/> | <input type="checkbox"/> | 26. Ever had an eating disorder?.....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had seizures?.....                                  | <input type="checkbox"/> | <input type="checkbox"/> | 27. Ever had back problems?.....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever had chest pain during or after exercise? .....      | <input type="checkbox"/> | <input type="checkbox"/> | 28. Ever had emotional difficulties for which           |                          |                          |
| 14. Ever had high blood pressure?.....                       | <input type="checkbox"/> | <input type="checkbox"/> | professional help was sought?.....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Ever been diagnosed with a heart murmur?.....            | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

Please explain any “yes” answers, noting the number of the questions.

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**Which of the following has the participant had?**

- Measles
- Chicken pox
- German measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

**Please give all dates of immunization for:**

| Vaccine                 | Dates: | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr | Mo/Yr |
|-------------------------|--------|-------|-------|-------|-------|-------|-------|
| DTP                     |        | _____ | _____ | _____ | _____ | _____ | _____ |
| TD (tetanus/diphtheria) |        | _____ | _____ | _____ | _____ | _____ | _____ |
| Tetanus                 |        | _____ | _____ | _____ | _____ | _____ | _____ |
| Polio                   |        | _____ | _____ | _____ | _____ | _____ | _____ |
| MMR                     |        | _____ | _____ | _____ | _____ | _____ | _____ |
| or Measles              |        | _____ | _____ | _____ | _____ | _____ | _____ |
| or Mumps                |        | _____ | _____ | _____ | _____ | _____ | _____ |
| or Rubella              |        | _____ | _____ | _____ | _____ | _____ | _____ |
| Haemophilus influenza B |        | _____ | _____ | _____ | _____ | _____ | _____ |
| Hepatitis B             |        | _____ | _____ | _____ | _____ | _____ | _____ |
| Varicella (chicken pox) |        | _____ | _____ | _____ | _____ | _____ | _____ |

TB Mantoux Test

Date of last test \_\_\_\_\_  
 Result:  Positive  Negative

Use this space to tell us more about your camper. Please provide any additional information about the participant’s behavior and physical, emotional, and mental health about which the camp should be aware. Have there been any recent changes in your family life that the camp should be aware of? What goals do you or your camper have for their camp experience?

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

Address \_\_\_\_\_

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

Address \_\_\_\_\_

Is the participant covered by family medical/hospital insurance?  Yes  No

If so, carrier or plan name \_\_\_\_\_ Group # \_\_\_\_\_

Photocopy of front and back of health insurance card must be attached to this form.

# Health Care Recommendation by Licensed Medical Personnel

I examined this individual on \_\_\_\_\_. (Chapel Rock recommends exams within 24 months of camp attendance.)

BP \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant  is  is not able to participate in an active camp program.

The applicant is under the care of a physician for the following condition(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 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 staff at the camp \_\_\_\_\_  
\_\_\_\_\_

|   |
|---|
| <p><b>Signature of Licensed Medical Personnel</b> _____</p> <p>Printed _____ Title _____</p> <p>Address _____</p> <p>Phone _____ Date _____</p> |
|---|

*For camp use only*

|   |
|---|
| <p><b>Screening Record</b></p> <p>Date screened _____ Time _____ AM PM</p> <p>Meds received _____</p> <p>Updates/additions to health history noted <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None required</p> <p>Current health needs identified _____</p> <p>Observational notes _____</p> <p>Screened by _____</p> |
|---|