



# Camp St. Innocent

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Canadian Camping Association  
Association des camps du Canada

## COUNSELOR AND VOLUNTEER STAFF MEDICAL FORM INSTRUCTIONS

The information on this form is not part of the counselor/volunteer staff acceptance process. The intent of gathering this information is to provide camp health care personnel with the individual's medical history such that appropriate care may be offered. Any changes to this form must be given to the camp health care personnel upon arrival at camp. Please provide COMPLETE information so that the camp may be aware of your health needs. All information is regarded as STRICTLY CONFIDENTIAL and will only be shared with the staff who will be working with you and other necessary personnel (Camp Director, Nurse, Kitchen Coordinator, etc.), as appropriate. ONE FORM required for EACH counselor/volunteer staff.

<b>APPLICANT NAME:</b> _____				
Last Name	First Name	Middle Int		
SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female			DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR	
<b>ADDRESS:</b> _____				
(Street, include Apt. number)	City	Prov/State	Postal/Zip Code	Country
<b>TELEPHONE NBR:</b> _____		<b>OTHER PHONE NBR:</b> _____		
<b>EMERGENCY CONTACT:</b>	NAME:		RELATIONSHIP:	
	HOME PHONE:	WORK PHONE:	CELL PHONE:	
<b>FAMILY PHYSICIAN NAME:</b>			<b>TELEPHONE NBR:</b>	
<b>HEALTH INSURANCE – REQUIRED FOR ALL IN ATTENDANCE</b>				
<b>For Canadian residents:</b> Please submit a photocopy of the provincial Health Care/Medicare Card along with your application. Health Care/Medicare Card #: _____ Province: _____				
<b>For U.S. residents:</b> A photocopy of the front and back of your health insurance card must be attached to this form. Carrier/Plan Name: _____ Group #: _____ ID #: _____				

## GENERAL QUESTIONS

Do you or have you:		Yes	No			Yes	No
1	Had any recent injury, illness, or disease?	<input type="checkbox"/>	<input type="checkbox"/>	19	Ever had joint problems (i.e., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
2	Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	20	Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
3	Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	21	Have any skin problems (i.e., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
4	Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	22	Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
5	Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	23	Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
6	Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	24	Had mononucleosis in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
7	Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	25	Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
8	Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	26	Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
9	Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	27	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"/>	28	Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
11	Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29	Ever had bleeding disorders?	<input type="checkbox"/>	<input type="checkbox"/>
12	Ever had motion sickness?	<input type="checkbox"/>	<input type="checkbox"/>	30	Have fainting spells?	<input type="checkbox"/>	<input type="checkbox"/>
13	Been known to have nightmares?	<input type="checkbox"/>	<input type="checkbox"/>	31	Have chronic cramps?	<input type="checkbox"/>	<input type="checkbox"/>
14	Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	32	Ever had convulsions?	<input type="checkbox"/>	<input type="checkbox"/>
15	Ever had chest pain during or after exercise?....	<input type="checkbox"/>	<input type="checkbox"/>	33	Have HIV?	<input type="checkbox"/>	<input type="checkbox"/>
16	Ever had high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>	34	Ever had a hernia?	<input type="checkbox"/>	<input type="checkbox"/>
17	Ever been diagnosed with a heart murmur?.	<input type="checkbox"/>	<input type="checkbox"/>	35	Other (If yes, please explain)	<input type="checkbox"/>	<input type="checkbox"/>
18	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.)

Which of the following have you had?	Please give DATES of immunization for: (OR photocopy of immunization booklet)
Measles <input type="checkbox"/>	Diphtheria/Tetanus/Pertussis/Polio (DTaP-IPV)
Chicken Pox <input type="checkbox"/>	Tetanus/Diphtheria (Tdap)
Ruebella (German Measles) <input type="checkbox"/>	Tetanus booster (Td)
Mumps <input type="checkbox"/>	Pneumococcus
Hepatitis A <input type="checkbox"/>	MMR
Hepatitis B <input type="checkbox"/>	Megingococcus
Hepatitis C <input type="checkbox"/>	Haemophilus influenza B (HIB)
TB Mantoux Text (aka PPD):	Hepatitis B
Date of last test: _____	
Result: <input type="checkbox"/> Positive	Varicella (chicken pox)
<input type="checkbox"/> Negative	

# Camp St. Innocent 2017 Counselor/Volunteer Medical Form

## OVER-THE-COUNTER MEDICINE

Please indicate 'Yes' or 'No' next to each over-the-counter medication that you can or cannot take.

	Yes	No		Yes	No		Yes	No
Tylenol Products	<input type="checkbox"/>	<input type="checkbox"/>	Pepto Bismol	<input type="checkbox"/>	<input type="checkbox"/>	Antacids	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen Products	<input type="checkbox"/>	<input type="checkbox"/>	Cough Syrup	<input type="checkbox"/>	<input type="checkbox"/>	Antiseptic Throat Spray	<input type="checkbox"/>	<input type="checkbox"/>
Dimetapp Products	<input type="checkbox"/>	<input type="checkbox"/>	Cough Lozenges	<input type="checkbox"/>	<input type="checkbox"/>	Sterile Eye Irrigate	<input type="checkbox"/>	<input type="checkbox"/>
Mucinex Products	<input type="checkbox"/>	<input type="checkbox"/>	Sudafed	<input type="checkbox"/>	<input type="checkbox"/>	External Ointments	<input type="checkbox"/>	<input type="checkbox"/>
Benadryl Spray/Lotion/Pill	<input type="checkbox"/>	<input type="checkbox"/>	Gravol	<input type="checkbox"/>	<input type="checkbox"/>	Any Other?	<input type="checkbox"/>	<input type="checkbox"/>

## MEDICATIONS CURRENTLY BEING TAKEN

Med #1: _____	Dosage: _____	Form (pill/inhalation/injection): _____	Times/Day: _____
Reason for Taking: _____			
Med #2: _____	Dosage: _____	Form (pill/inhalation/injection): _____	Times/Day: _____
Reason for Taking: _____			
Med #3: _____	Dosage: _____	Form (pill/inhalation/injection): _____	Times/Day: _____
Reason for Taking: _____			

## ALLERGIES

*Describe reaction and management of reaction*

Medication Allergies: \_\_\_\_\_

Food Allergies and/or Intolerances: \_\_\_\_\_

Other Allergies (include insect stings, hay fever, asthma, animal dander, etc.): \_\_\_\_\_

## SCREENING RECORD – FOR CAMP USE ONLY

Date Screened: \_\_\_\_\_ Time: \_\_\_\_\_ Screen by: \_\_\_\_\_

Meds Received: \_\_\_\_\_

Updates/additions to health history noted:  Yes  No  None Required

Current health needs identified: \_\_\_\_\_

# Camp St. Innocent 2017 Counselor/Volunteer Medical Form

## OTHER INFORMATION

*We want you to have the best possible experience while at camp. All information is regarded as STRICTLY CONFIDENTIAL and will only be shared with staff working with you and other necessary personnel (Camp Director, Nurse, Kitchen Coordinator, etc.), if required and as appropriate.*

- Date of last physical examination: \_\_\_\_\_
- Have you ever been away to overnight camp before? Yes No
- Dietary restrictions: None Vegetarian Vegan Diabetic Other  
\_\_\_\_\_
- Water sport activities: I give / I do not give my permission to partake in the water activities.
- Swimming ability: Cannot Swim Beginner Intermediate Expert
- Are there special fears, anxiety, worries or concerns you have about camp (extreme shyness, afraid of the dark, etc)?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Are there circumstances in your 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.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Use this space to provide any additional information about your behavior and physical, emotional, or mental health in which the Camp should be aware.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**COUNSELOR/VOLUNTEER STAFF  
AUTHORIZATION, 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 below. 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. In the event of 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 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. Innocent 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. Innocent, its leaders, clergy, employees, and/or volunteers liable for damages, losses, disease, or injuries incurred by the subject of this form.

I agree that I will abide by all the rules and guidelines set forth by Camp St. Innocent for the safety and good health of the campers at camp. I also agree that if I have to return home due to discipline violations, it will be at my own expense.

I give permission to participate in all camp activities, *except* the following **(Please print name, sign and date. If there are any exceptions, please state activity and reason for denial of permission for each activity denied)**:

Activity	Reason for Denial of Permission
_____	_____
_____	_____
_____	_____

Name (Print)	Signature	Date
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**COUNSELOR/VOLUNTEER STAFF AUTHORIZATION AND WAIVER**

I agree to indemnify and hold harmless, the Antiochian Orthodox Christian Archdiocese, Camp Innocent, 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. Innocent, 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, or on my behalf or by anyone else as a result of any accident of injury occurring to me.

I hereby release Camp St. Innocent Association, it's agents, members, clergy, employees, volunteers and the Antiochian Orthodox Church of North America and hold them harmless from any and all liability for any accident, injury or any claim arising out of myself or the said camper's use of Camp St. Innocent facilities, owned or leased, or by virtue of participation in any of it's programs. In case of emergency, I hereby authorize the Camp Personnel to secure medical advice and services as may be deemed necessary for the health and safety of myself.

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**Name (print)**

**Signature**

**Date**