Camp St. Innocent 2018

c/o 9319 – 190 A Street, Edmonton, Alberta, Canada T5T 5P8 Phone: (780) 484-2515

Email: campstinnocent@gmail.com website: www.campstinnocent.org

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.

APPLICANT NAME: ______________________ ______________________ _____
Last Name First Name Middle Int

SEX: ☐ Male ☐ Female

DATE OF BIRTH: ________ / ______ /______
MONTH DAY YEAR

ADDRESS: ____
(Street, include Apt. number) City Prov/State Postal/Zip Code Country

TELEPHONE NBR: _____________________________ **OTHER PHONE NBR:** ______________________

EMERGENCY CONTACT:	NAME:		RELATIONSHIP:
	HOME PHONE:	WORK PHONE:	CELL PHONE:

FAMILY PHYSICIAN NAME:	**TELEPHONE NBR:**

HEALTH INSURANCE – REQUIRED FOR ALL IN ATTENDANCE

For Canadian residents: Please submit a photocopy of the provincial Health Care/Medicare Card along with your application.

Health Care/Medicare Card #: ____________________________________ Province: ______________________

For U.S. residents: A photocopy of the front and back of your health insurance card must be attached to this form.

Carrier/Plan Name: ___________________________Group #:_____________________ ID #:__________________

Camp St. Innocent 2018 Counselor/Volunteer Medical Form

GENERAL QUESTIONS

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

Please explain any 'Yes' answers, noting the number of the questions. (Use additional pages if necessary.)

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Which of the following have you had?		**Please give DATES of immunization OR photocopy of immunization booklet OR indicate if up-to-date)**	
Measles	❑	Diphtheria/Tetanus/Pertussis/Polio (DTaP-IPV)	
Chicken Pox	❑	Tetanus/Diphtheria (Tdap)	
Ruebella (German Measles	❑	Tetanus booster (Td)	
Mumps	❑	Pneumococcus	
Hepatitis A	❑	MMR	
Hepatitis B	❑	Megingococcus	
Hepatitis C	❑	Haemophilus influenza B (HIB)	
TB Mantoux Text (aka PPD): Date of last test: ______________		Hepatitis B	
Result: ❑ Positive ❑ Negative		Varicella (chicken pox)	

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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	❑	❑	Pepto Bismol	❑	❑	Antacids	❑	❑
Ibuprofen Products	❑	❑	Cough Syrup	❑	❑	Antiseptic Throat Spray	❑	❑
Dimetapp Products	❑	❑	Cough Lozenges	❑	❑	Sterile Eye Irrigate	❑	❑
Mucinex Products	❑	❑	Sudafed	❑	❑	External Ointments	❑	❑
Benadryl Spray/Lotion/Pill	❑	❑	Gravol	❑	❑	Any Other? ______________________	❑	❑

MEDICATIONS CURRENTLY BEING TAKEN			
Med #1:_________________________ Reason for Taking:	Dosage: __________	Form (pill/inhalation/injection): ______________________________	Times/Day: _________
Med #2:_________________________ Reason for Taking:	Dosage: ___________	Form (pill/inhalation/injection): ______________________________	Times/Day: _________
Med #3:_________________________ Reason for Taking:	Dosage: ___________	Form (pill/inhalation/injection): ______________________________	Times/Day: _________

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: ____

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

Current health needs identified: ____

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OTHER INFORMATION

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

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- 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.

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- Use this space to provide any additional information about your behavior and physical, emotional, or mental health in which the Camp should be aware.

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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

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____

____

____________________ ____________________ ____________

Name (Print) Signature Date

Camp St. Innocent **2018 Counselor/Volunteer Medical Form**

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**