

# St. Xenia Orthodox Church Camp

## Health History Form

Health history must be filled out by parents/guardians of minors- update **required annually**.

**\*Please note:** a **Physician's Consent Form** (separate attachment) is also required every **24 months**.

### CAMPER INFORMATION

Last Name

First Name

Middle Initial

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of Birth (mm/dd/yyyy)

Gender

\_\_\_\_\_

Male     Female

Home Address

\_\_\_\_\_

City

State

\_\_\_\_\_

\_\_\_\_\_

Postal / Zip Code

Country

\_\_\_\_\_

\_\_\_\_\_

## HEALTH HISTORY

*The following information must be filled in by the parent/guardian. The intent of this information is to provide camp healthcare personnel with 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 the participant's arrival in camp. Provide complete information so the camp can be aware of your child's/your needs.*

### **ALLERGIES**

**Medication Allergies** *(List all known; describe any reaction and management of the reaction.)*

---

**Food Allergies** *(List all known; describe any reaction and management of the reaction.)*

---

**Other Allergies** *(List...; describe... Include insect stings, hay fever, asthma, animal dander, etc.)*

---

### **MEDICATIONS**

\_\_\_ This person takes NO MEDICATIONS on a routine basis.

\_\_\_ This person TAKES MEDICATIONS on a routine basis as follows:

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

**Medication #1**

---

Dosage

---

Specific times taken each day Reason for taking

---

**Medication #2**

---

**Dosage**

---

**Specific times taken each day Reason for taking**

---

**Medication #3**

---

**Dosage**

---

**Specific times taken each day Reason for taking**

---

**Additional Medications** (List below, and the Registrar and/or Camp Nurse will contact you for further information. Identify any medications taken during the school year that the participant does/may not take during the summer)

---

**RESTRICTIONS**

**Dietary Restrictions** (*Check any that apply*)

- 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)**
- 

**Restrictions to Activity** (*Explain any physical restrictions to activity, and adaptations or accommodations that may be helpful*).

---

## **GENERAL QUESTIONS**

**Has/does the participant** (*check all that apply; explain “yes” answers below*):

- 1. Had any recent injury, illness or infectious disease?
- 2. Have a chronic or recurring illness/condition?
- 3. Ever been hospitalized?
- 4. Ever had surgery?
- 5. Have frequent headaches?
- 6. Ever had a head injury?
- 7. Ever been knocked unconscious?
- 8. Wear glasses, contacts, or protective eyewear?
- 9. Ever had frequent ear infections?
- 10. Ever passed out during or after exercise?
- 11. Ever been dizzy during or after exercise?
- 12. Ever had seizures?
- 13. Ever had chest pain during or after exercise?
- 14. Ever had high blood pressure?
- 15. Ever been diagnosed with a heart murmur?
- 16. Ever had back problems?
- 17. Ever had problems with joints? (e.g. knees, ankles)?
- 18. Have an orthodontic appliance being brought to camp?
- 19. Have any skin problems (e.g. itching, rash, acne)?
- 20. Have diabetes?
- 21. Have asthma?
- 22. Had mononucleosis in the past 12 months?
- 23. Had problems with diarrhea/constipation?
- 24. Have problems with sleepwalking?
- 25. If female, have an abnormal menstrual history?
- 26. Have a history of bed-wetting?
- 27. Ever had an eating disorder?
- 28. Ever had emotional difficulties for which professional help was sought?

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

---

**Which of the following has the participant had? (check all that apply)**

Measles

Chicken Pox

German measles

Mumps

Hepatitis A

Hepatitis B

Hepatitis C

TB Mantoux test

Date of last test: \_\_\_\_\_

Result:  Positive  Negative

**BEHAVIORAL NEEDS**

*We hope to accommodate all youth who wish to attend St. Xenia Camp, so it is important that we have the necessary information to prepare properly for their needs. Please indicate any challenges your camper experiences, and someone in Camp Leadership will reach out to discuss further:*

ASD

ADD/ADHD

Anxiety

Other: \_\_\_\_\_

Depression

PTSD

BPD

**IMMUNIZATIONS**

*All campers must have a record of immunization or non-immunization on file. All parents and guardians should be aware that immunization is not required to attend Saint Xenia Camp; therefore, there may be campers with and without any given immunization. Immunization status is confidential medical information, and will therefore not be shared.*

Has your camper received any immunizations?  YES  NO

If YES, provide your camper's immunization record by:

- Email (w/ attention to the Registrar) to: [stxeniacamp@gmail.com](mailto:stxeniacamp@gmail.com)
- Traditional mail to: St. Xenia Camp Registrar  
PO Box 781  
Etna, CA 96027

**MEDICAL INSURANCE INFORMATION**

Campers must be medically insured to attend camp. Please provide a copy of the front and back of the camper's medical insurance card by:

- Email (w/ attention to the Registrar) to: [stxeniacamp@gmail.com](mailto:stxeniacamp@gmail.com)
- Traditional mail to: St. Xenia Camp Registrar  
PO Box 781  
Etna, CA 96027

## PARENT/GUARDIAN AUTHORIZATIONS

**This must be completed for attendance.\***

- **This health history is correct and complete as far as I know.**
- **The person herein described has permission to engage in all camp activities as noted.**
- **I hereby give permission to the camp to provide routine 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 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.**

**Signature of Parent/Guardian**

**Date**

\_\_\_\_\_

\_\_\_\_\_

**Email**

**Phone**

\_\_\_\_\_

\_\_\_\_\_

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

**Signature of Camper**

**Date**

\_\_\_\_\_

\_\_\_\_\_