Health Form

Name: _____Birthdate: _____Gender: ☐ Male ☐ Female

Insurance Information

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

If so, indicate carrier or plan name: _____ Group #: _____

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

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all youth activities except as noted. I hereby give permission to the Taxiarchae/Archangels Greek Orthodox Church 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 insurance purposes. I give permission to the parish staff and/or volunteers 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 parish staff and/or volunteers to secure and administer treatment, including hospitalization, for the person named above.

Signature of parent/guardian: _____

Printed Name:_____ Date:_____

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

Signature of GOYAn: _____ Date: _____

Health History

The parent/guardian, or adult camper or staff member must fill in the following information. The intent of this information is to provide health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Provide complete information so that we can be aware of your needs.

Allergies	Describe reaction and management of the reaction
Medication:	
Food:	
Other Allergies (include insect stings, hay fever, asthma, animal dander, etc.)	

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire weekend. 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 medication on a routine basis.

☐ This person takes medications as follows:

Medication	Dosage	Specific times taken each day	Reasons for taking

Attach additional pages for more medications.

Dietary Restrictions

X		X		X	
	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)				

GENERAL QUESTIONS (Explain "yes" answers below.)

Has/does the participant:	Yes	No	Has/does the participant:	Yes	No
Had any recent injury, illness or infectious disease?			Have a chronic or recurring illness/condition?		
Ever had problems with joints (e.g. knees, ankles)?			Ever been hospitalized?		
Have an orthodontic appliance brought to camp?			Have any skin problems (e.g. itching, rash, acne)?		
Ever had surgery?			Have diabetes?		
Have frequent headaches?			Have asthma?		
Wear glasses, contacts or protective eye wear?			Had mononucleosis in the past 12 months?		
Ever had frequent ear infections?			Had problems with diarrhea/constipation?		
Ever passed out during or after exercise?			Have problems with sleepwalking?		
Ever been dizzy during or after exercise?			If female, have an abnormal menstrual history?		
Ever had seizures?			Have a history of bed-wetting?		
Ever had chest pain during or after exercise?			Ever had an eating disorder?		
Ever had high blood pressure?			Ever had emotional difficulties for which professional help was sought?		
Ever been diagnosed with a heart murmur?			Ever had back problems?		

Please explain any "yes" answers, referencing the question. _____

_____

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. _____ _____

_____

_____

Name of family physician:_____Phone:_____

Address: _____

Name of family dentist/orthodontist: _____Phone: _____

Address: _____