



Health Record, Examination and Medical Release Form

The following information is requested to assist Christodora-Manice Education Center in providing appropriate care for your student. Each student's Health Record and Examination Form is REQUIRED TO BE SUBMITTED 2 WEEKS PRIOR TO THE DEPARTURE DATE for your student's attendance to the Manice Education Center. A Physical Examination and a review of the Health History is also required to be completed by an approved licensed medical provider within 24 months prior to participation in a Christodora-Manice Education Center program. We treat all personal medical information with confidentiality. A student's medical information is securely stored and will be shared only with pertinent program staff and medical providers.

Student Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age at camp \_\_\_\_\_  
Last First Middle

Home Address \_\_\_\_\_  
Building number Street Apartment City State Zip

Social security number of participant \_\_\_\_\_ Gender: ↑ Male ↑ Female (circle one)

Custodial Parent/Guardian \_\_\_\_\_ Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Home Address \_\_\_\_\_  
(if different from above) Building number Street Apartment City State Zip

Business Address \_\_\_\_\_ Work phone \_\_\_\_\_  
Building number Street City State Zip

Second Parent/Guardian \_\_\_\_\_ Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Home Address \_\_\_\_\_  
(if different from above) Building number Street Apartment City State Zip

Business Address \_\_\_\_\_ Work phone \_\_\_\_\_  
Building number Street City State Zip

**If parent/guardian not reachable in an emergency notify:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Best number to reach \_\_\_\_\_

Address \_\_\_\_\_ Work or Cell phone \_\_\_\_\_

**Insurance Information**

Is the participant covered by a work/family/ or individual medical/hospital insurance? ↑ Yes ↑ No

Insurance Carrier/Plan Name \_\_\_\_\_ Group/Policy # \_\_\_\_\_

➔Please attach a copy of the front and back of health insurance card.

**Authorization for Participation:** section must be read, filled out, and signed by parent or guardian for participant attendance.\*

I hereby give permission to the Manice Education Center (MEC) trained staff to administer standard first aid, including over the counter medications unless I listed any restrictions herein. I hereby give permission to the MEC staff to administer all prescription medication I have provided to MEC for my student while at MEC. I hereby give permission to the medical personnel selected by the MEC Director, Assistant Director, Field Teacher or designate to order x-rays or other routine tests and treatment for my student, and in the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the above mentioned to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for my student as named above. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to MEC to arrange necessary related transportation for this participant. This completed form will be photo copied for off site trips.

Signature of Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

Print name: \_\_\_\_\_

**Participant agreement:**

I understand and agree to abide by restrictions or requirements place on my participation as indicated throughout this form.

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

*\*If for religious reasons you cannot sign and authorize this form, contact Christodora for a waiver to sign for attendance.*

**Health History**

The following Health History information must be filled out by the **parent/guardian** and reviewed by the examining licensed medical provider. Please provide complete information so that the Christodora-Manice Education Center can be aware of your youth participant's entire needs.

	Yes	No		Yes	No
1. Had any recent injury or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	15. Have any skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have chronic recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	16. Had mononucleosis in past year?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	17. Had serious digestive problems?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have problems with sleep walking?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have history of or currently bed wetting?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a serious head injury?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have or had eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	21. Wear eye glasses or contacts?	<input type="checkbox"/>	<input type="checkbox"/>
8. Ever passed out during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	22. Have orthodontic appliance?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	23. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever had chest pain during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have or had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever had/have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	25. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had a diagnosis of heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had serious back problems?	<input type="checkbox"/>	<input type="checkbox"/>			
14. Ever had serious joint problems?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any **Yes** answers above:

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**Current Medication Being provided:**

↑ This student takes NO medication on a routine basis at this time, and is bringing no medication to camp.

↑ This student takes medication as follows:

Name of Med #1 _____ Dosage _____ Frequency _____ Reason for taking: _____
Name of Med #2 _____ Dosage _____ Frequency _____ Reason for taking: _____
Name of Med #3 _____ Dosage _____ Frequency _____ Reason for taking: _____
Name of Med #4 _____ Dosage _____ Frequency _____ Reason for taking: _____
Name of Med #5 _____ Dosage _____ Frequency _____ Reason for taking: _____

➔ Attach additional pages as needed for more medications.

➔ An updated **Authorization to Administer Medication Form** is due the date of departure.

Our trained staff will administer applicable over the counter medications for first aid treatments and minor ailments, and/or including sunscreen and insect repellent for all participants to the Christodora-Manice Education Center. **Please list any over the counter medications your student is allergic to or may not take due to an undesirable medical interaction with their current prescribed medications and the reason why.** You are responsible for listing only the over the counter medications your student may not take.

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**Allergies:**

Medication allergies	Medication taken (if any), reaction and management of reaction
_____	_____
_____	_____
_____	_____

Food allergies	Medication taken (if any), reaction and management of reaction
_____	_____
_____	_____
_____	_____

Other environmental /seasonal/ insect	Medication taken (if any), reaction and management of reaction
_____	_____
_____	_____
_____	_____

**Restrictions and other considerations:**

Dietary: (does not eat, allergic to, special diet because...)

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Activity: (due to recent or chronic medical conditions, adaptations, or limitations...)

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Please use this space to provide additional information about the participant (physical, mental, emotional, behavior) that you feel the camp should be aware of and may assist in provide safe and beneficial participation in the program.

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**Immunization History:**

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Which has the participant had or has (dates if available):
DTP		_____	_____	_____	_____	↑ Measles _____
TD (tetanus/diphtheria)		_____	_____	_____	_____	↑ Chicken pox _____
Tetanus		_____	_____	_____	_____	↑ German measles _____
Polio		_____	_____	_____	_____	↑ Mumps _____
MMR		_____	_____	_____	_____	↑ Hepatitis A _____
Or measles		_____	_____	_____	_____	↑ Hepatitis B _____
Or mumps		_____	_____	_____	_____	↑ Hepatitis C _____
Or Rubella		_____	_____	_____	_____	↑ Rheumatic Fever _____
Haemophilus influenza B		_____	_____	_____	_____	↑ Seizures _____
Hepatitis B		_____	_____	_____	_____	↑ Diabetes _____
Varicella (chicken pox)		_____	_____	_____	_____	↑ Asthma _____
Pneumococcal Conj. (PCV)		_____	_____	_____	_____	
Other		_____	_____	_____	_____	

Name of family physician \_\_\_\_\_ phone \_\_\_\_\_

Address \_\_\_\_\_

Name of dentist/orthodontic \_\_\_\_\_ phone \_\_\_\_\_

Address \_\_\_\_\_

**Medical Examination: to be filled out by an approved licensed medical provider.**

I have examined the individual on this date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood pressure: \_\_\_\_\_

The applicant is under the care of a physician for the following conditions: \_\_\_\_\_

Treatment to be continued at camp: \_\_\_\_\_

Description of any limitation or restriction on camp activities: \_\_\_\_\_

Additional information for health care staff at the camp: \_\_\_\_\_

➔ Attach additional examination results as available.

I have examined the person herein described and reviewed his/her health history.

In my opinion, the above person  **is**  **is not** (check one) able to participate in active camp programs.

Signature of Licensed Medical Personnel: \_\_\_\_\_ Date \_\_\_\_\_

Printed name: \_\_\_\_\_ Title \_\_\_\_\_

Health Care Organization/Clinic name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_