Christodora
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Christodora's
Medical Form Guide

In order to best prepare and provide for your youth, all medical forms must be submitted

before June 1, 2017

What do you need to do?

1. Make an appointment with your doctor as soon as possible—it may take a few weeks to a few months to see your doctor for a physical examination.

   IMPORTANT: If there are any changes to your youth's health or medications after you have submitted this form, please contact the Christodora office at (212) 371-5225. It is important that we are aware of the most current medical information about your youth to best provide care during their stay.

2. Parent/Guardian must complete all sections on Pages 1—5 and sign/date the bottom of Page 1.

   a. Immunization History – We need all immunizations to be listed.

      i. Complete the Immunization History on Page 5 of the Medical Form

      OR

      ii. Attach a copy of the immunization records from your doctor.

3. Have your doctor (licensed medical provider) review Pages 1-5 and complete, sign, & date Page 6 during your physical exam. Please make sure they check the box indicating your youth is able to participate in active camp programs.

4. Please complete Page 7 – Authorization to Administer Medication. All medications must be sent to camp in unexpired & original packaging from the pharmacy. We cannot accept pill-boxes, zip lock bags, etc. We will need you to update this form on the start date of your youth's program, if anything has changed.

5. If your youth has an epi-pen or asthma inhaler, make sure you sign both signature lines at the bottom of Page 7.

6. **Please do not leave any section blank. Write "N/A" if a section does not apply to your child.**

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Christodora
Health Record, Examination and Medical Release Form

The following information is requested to assist Christodora in providing appropriate care for your child. 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 program. We treat all personal medical information with confidentiality. A child's medical information is securely stored and will be shared only with pertinent program staff and medical providers.

Part I: General Information

Youth Name_____ Birth Date_____ Age at Start of Program_____
Month/Day/Year

Home Address_____
Street Apartment City State Zip

Social Security Number of Youth Participant_____ ☐ Male ☐ Female

Parent/Guardian_____ Home Phone_____ Cell Phone_____

Home Address _____
(if different from above) Street Apartment City State Zip

Business Address _____
Street Apartment 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 - Please attach a copy of the front and back of the youth's health insurance card.

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

Insurance Carrier/Plan Name_____ Group/Policy #_____

✦✦ Authorization for Participation:

Below section must be signed by parent or guardian for youth to participate in camp:

I hereby give permission to trained staff at Christodora to administer standard first aid, and provide over the counter medications unless I listed any restrictions herein. I hereby give permission to Christodora staff to provide all prescription medication I have provided to Christodora for my youth while at a Christodora program. I hereby give permission to the medical personnel selected by the Christodora staff to order x-rays or other routine tests and treatment for my youth, 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 youth as named above. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to Christodora to arrange necessary related transportation for this participant. This completed form will be photo copied for offsite trips.

_____ ___/___/_____
Parent/Legal Guardian Signature **Date**

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

Part II: Health History - (You must check yes/no on each line)

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 Christodora can best provide for your youth's needs.

Ever had or has:	Yes	No	Alguna vez tuvo o tiene:	Si	No
Recent injury or infectious disease			Lesión reciente/enfermedad infecciosa		
Chronic recurring illness/condition			Enfermedad crónica recurrente/condición		
Been hospitalized			Sido hospitalizado		
Surgery			Cirugía		
Frequent headaches			Dolores de cabeza frecuentes		
Serious head injury neurological impairment			Traumatismo craneal grave deterioro neurológico		
Frequent ear infections			Infecciones de oído frecuentes		
Passed out during exercise			Se desmayó durante el ejercicio		
Seizures			Convulsiones		
Chest pain during exercise			Dolor en el pecho durante el ejercicio		
High blood pressure			Presión arterial alta		
Diagnosis of heart murmur			Diagnóstico de soplo cardíaco		
Diagnosis of heart disease			Diagnóstico de enfermedades del corazón		
Irregular heartbeat/palpitations			Cardíaco acelerado / irregular palpitaciones		
Family history of heart attack			Antecedentes familiares de ataque al corazón		
Circulation problems			Problemas de circulación		
Frostbite			Congelación		
Heatstroke or heat related illness			Golpe de calor o una enfermedad relacionada con el calor		
Tuberculosis/positive TB test			Tuberculosis o prueba positiva de tuberculosis		
Hepatitis or other liver disorders			Hepatitis u otros trastornos hepáticos		
Lyme disease			Enfermedad de Lyme		
Bleeding/blood disorder			Sangrado o trastorno sanguíneo		
Sickle cell anemia or trait			Anemia de células falciformes o rasgo		
Hypoglycemia (low blood sugar)			La hipoglucemia (bajo nivel de azúcar en la sangre)		
Cancer			Cáncer		
Thyroid problems			Problemas de la tiroides		
Gastro-intestinal problems			Problemas gastrointestinales		
Serious back problems			Serios problemas de espalda		
Serious joint problems			Serios problemas en las articulaciones		
Broken bones within the past year			Los huesos rotos en el último año		
Skin problems			Problemas de la piel		
Mononucleosis in past year			Mononucleosis en el último año		
Serious digestive problems			Problemas digestivos graves		
Problems with sleep walking			Problemas con el sonambulismo		
Currently bed wetting			Actualmente orinarse en la cama		
Kidney problems			Problemas renales		
Urinary or reproductive tract disorders			Trastornos del tracto urinario o reproductivos		
Eating disorder			trastorno de la alimentación		
Wear eye glasses or contacts			Usa gafas o contactos		
Hearing impairment			La discapacidad auditiva		
Orthodontic appliance			Usa aparato de ortodoncia		
Abnormal menstrual history			Si es mujer, tiene una historial de menstruacion normal		
Is currently pregnant			Si es, mujer, actualmente se encuentra embarazada		
Emotional difficulties			Dificultades emocionales		
Diabetes			Diabetes		
Asthma or respiratory problems			Asma o problemas respiratorios		
Motion sickness			La cinetosis		

If you answer "yes" to any of the item, please explain below. Include the following:

- ◆ Specific symptoms that are occurring
- ◆ How long symptom/condition lasts
- ◆ Date of last occurrence
- ◆ How often symptom/condition occurs
- ◆ How you care for symptom/condition
- ◆ Any restrictions

Si su respuesta fue "si" para alguna pregunta anterior, favor de explicar en el formulario adjunto.

A. Current Medication Being Provided (check one):

☐ This youth takes medication as follows:

Medication Name (List Below)	**Taken For** (Symptom/Condition)	**Dosage** (Size)	**Frequency** (How often? What time?)

☐ This youth takes NO medication on a routine basis at this time and is bringing no medication to camp

B. Mental Health

1. Has youth been diagnosed or treated for any of the following currently or within the past year?

Y ☐ N ☐ Attention Deficit Disorder (ADD)
Y ☐ N ☐ Adjustment Disorder
Y ☐ N ☐ Anxiety Disorder
Y ☐ N ☐ Disruptive Behavior Disorder
Y ☐ N ☐ Eating Disorder
Y ☐ N ☐ Impulse Control Disorder
Y ☐ N ☐ Learning Disorder
Y ☐ N ☐ Developmentally Disabled
Y ☐ N ☐ Mood Disorder
Y ☐ N ☐ Personality Disorder
Y ☐ N ☐ Pervasive Developmental Disorder
Y ☐ N ☐ Substance Related Disorder
Y ☐ N ☐ Schizophrenia
Y ☐ N ☐ Other: _____

2. Has youth received treatment/therapy for any of the following, either currently or in the past year?

Y ☐ N ☐ Medication(s)
Y ☐ N ☐ Out Patient Counseling
Y ☐ N ☐ Day Treatment
Y ☐ N ☐ Psychiatric Hospitalization
Y ☐ N ☐ Residential Treatment
Y ☐ N ☐ Personality Disorder

3. Has youth experienced any of the following significant events within the past year? If yes, please explain:

Y ☐ N ☐ Serious Illness _____
Y ☐ N ☐ Serious accident/injury _____
Y ☐ N ☐ Self harm _____
Y ☐ N ☐ Expulsion _____
Y ☐ N ☐ Incarceration _____
Y ☐ N ☐ Death of Family/Friend _____

4. Please arrange for a release of information with your youth's therapist and/or prescribing physician so we may contact them for further information as part of this screening process. Have you done so? **YES ☐ NO ☐**

5. Please provide the name and telephone & fax #s of your youth's therapist and/or prescribing physician:

Therapist _____ **Telephone #** _____
Fax # _____ **Email** _____

Prescribing Physician _____ **Telephone #** _____
Fax # _____ **Email** _____

Part III: Allergies, & Considerations

A. List Allergies

Allergy (List Below)	**Reaction** (List Below)	**Treatment for Allergy** (if any)
Medication Allergies:		
Food Allergies:		
Insect bites/stings Allergies:		
Environmental Allergies (seasonal, dust, etc.):		

☐ **This youth has NO known allergies to date.**

B. List restrictions and other considerations

Dietary: (does not eat, special diet because…)

_____

_____

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

_____

_____

Over-the-Counter Medication:

Please list any over the counter medications your youth is allergic to or may not take due to an undesirable medical interaction with their current prescribe medications and the reason why. You are responsible for listing only the over the counter medications your student may not take, in this section. Trained staff will provide applicable over the counter medications for first aid treatments and minor ailments, and/or including sunscreen and insect repellant for all participants at Christodora.

_____

_____

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.

_____

_____

_____

Part IV: Immunization History – (required for admissions to program)

Please complete each section below, or attach the full immunization records from your youth's pediatrician.

	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr		Participant had or has:	Dates (if available):
DTP*						Hepatitis C	
TD (tetanus/diphtheria)						Measles	
Tetanus						Chicken pox	
Polio						German measles	
MMR*						Mumps	
Or measles						Hepatitis A	
Or mumps						Hepatitis B	
Or Rubella						Rheumatic Fever	
Haemophilus influenza B							
Hepatitis B*							
Varicella (chickenpox)							
Pneumococcal Conj. PCV)							
Other							

Part V: Current Doctors

Name of family physician _____ phone_____

Name of dentist/orthodontist_____ phone_____

Part VI: Medical Examination

To be filled out by an approved licensed medical provider

I have examined _____ on this date: _____
Youth Participant's Name *Month/Day/Year*

Height: _____ Weight: _____ Blood pressure: _____

The applicant is under the care of a physician for the following medical conditions (including allergies, asthma, knee injuries.

_____

_____

****Please specify severity of above medical conditions (what are their triggers for asthma, allergies, etc.)****

_____

_____

Treatment to be continued while participating in a Christodora program: _____

_____

List and describe any limitation or restriction on camp activities: _____

_____

Please describe any concerns, with applicant actively paddling canoes, hiking uneven terrain, and/or carrying 25% of body weight:

_____

_____

Additional information for Christodora health care staff: _____

_____

_____

➔ Attach additional examination results as available. ←

I have examined the person herein described and reviewed his/her health history. By my signature, the above person is able to participate in active camp programs at Christodora and does not have any communicable diseases at the time of examination.

Signature of Licensed Medical Personnel: _____ Date _____

Printed name: _____ Title _____

Health Care Organization/Clinic name: _____

Address: _____

Phone: _____ Fax: _____

➔ ➔ Please attach a copy of the front and back of youth's health insurance card. ← ←

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Christodora's
Authorization to Administer Medication

Please list all medications that are prescription or over-the-counter and taken on a regular basis (such as "daily"). Medications must be in unexpired, original pharmacy packaging (not in pill boxes, ziplock bags, etc.).

Youth Name_____

I understand that Christodora---Manice Education Center does not assume responsibility for any medication you have not appropriately listed. I also understand that I must report any non-prescription medications my child is not permitted to take.

	Med 1:	Med 2:	Med 3:	Med 4:
Dosage				
Frequency				
Expiration Date				
Administration	☐ Oral ☐ Topical	☐ Oral ☐ Topical	☐ Oral ☐ Topical	☐ Oral ☐ Topical
Quantity at Camp				
Specific Directions				
Specific Precautions				
Possible Side Effects				

I hereby authorize Christodora---Manice Education Center to administer to my child the medication(s) listed above, in accordance with 105 CMR 430.160.

105 CMR 430. 160 (A) Medication prescribed for campers shall be kept in original containers bearing the pharmacy label, which shows the date of filling, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescribing practitioner, the name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over the counter medications for campers shall be kept in the original containers containing the original label, which shall include the directions for use.

105 CMR 430. 160 (C) Medication shall only be administered by the health supervisor or by a licensed health care professional authorized to administer prescription medications. If the health supervisor is not a licensed health care professional authorized to administer prescription medications, the administration of medications shall be under the professional oversight of the health care consultant. The health care consultant shall acknowledge in writing a list of all medications administered at the camp. **Medication prescribed for campers brought from home shall only be administered if it is from the original container, and there is written permission from the parent/guardian.**

105 CMR 430. 160 (D) When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be destroyed.

_____

Parent/Legal Guardian Signature **Date**

If your student carries an inhaler for asthma and/or an epi-pen for allergies, please read and sign below:

I hereby authorize my youth,_____, to carry and administer his/her own metered dose inhaler(s) and/or epi-pen(s) as currently prescribed by a licensed health care professional.

_____

Parent/Legal Guardian Signature **Date**