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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, 2019**

### 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. 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 4 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 1-4 and complete, sign, & date Page 5 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 6 – 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 6.
6. **Please do not leave any section blank. Write "N/A" if a section does not apply to your child.**





# 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

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

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

### ◆◆ 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, including over the counter medications unless I listed any restrictions herein. I hereby give permission to Christodora staff to administer 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 camper 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

## 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:**

**Alguna vez tuvo o tiene:**

Yes No

Si No

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.\**

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**A. Current Medication Being Provided (check one):**

- Yes** This youth takes medication.  
Please complete the Authorization to Administer Medication on page 7.
- NO** This youth takes no medication and & will not be bringing medication to camp.  
(Do not need to complete page 7 if you checked no.)

**B. Mental Health**

1. Has youth been diagnosed or treated for any of the following <u>currently</u> or within the <u>past year</u> ?	
Y <input type="checkbox"/> N <input type="checkbox"/> Attention Deficit Disorder (ADD) Y <input type="checkbox"/> N <input type="checkbox"/> Adjustment Disorder Y <input type="checkbox"/> N <input type="checkbox"/> Anxiety Disorder Y <input type="checkbox"/> N <input type="checkbox"/> Disruptive Behavior Disorder Y <input type="checkbox"/> N <input type="checkbox"/> Eating Disorder Y <input type="checkbox"/> N <input type="checkbox"/> Impulse Control Disorder Y <input type="checkbox"/> N <input type="checkbox"/> Learning Disorder	Y <input type="checkbox"/> N <input type="checkbox"/> Developmentally Disabled Y <input type="checkbox"/> N <input type="checkbox"/> Mood Disorder Y <input type="checkbox"/> N <input type="checkbox"/> Personality Disorder Y <input type="checkbox"/> N <input type="checkbox"/> Pervasive Developmental Disorder Y <input type="checkbox"/> N <input type="checkbox"/> Substance Related Disorder Y <input type="checkbox"/> N <input type="checkbox"/> Schizophrenia Y <input type="checkbox"/> N <input type="checkbox"/> Other: _____
2. Has youth received treatment/therapy for any of the following, either <u>currently</u> or in the <u>past year</u> ?	
Y <input type="checkbox"/> N <input type="checkbox"/> Medication(s) Y <input type="checkbox"/> N <input type="checkbox"/> Out Patient Counseling Y <input type="checkbox"/> N <input type="checkbox"/> Day Treatment	Y <input type="checkbox"/> N <input type="checkbox"/> Psychiatric Hospitalization Y <input type="checkbox"/> N <input type="checkbox"/> Residential Treatment Y <input type="checkbox"/> N <input type="checkbox"/> Personality Disorder
3. Has youth experienced any of the following significant events within the <u>past year</u> ? If yes, please explain:	
Y <input type="checkbox"/> N <input type="checkbox"/> Serious Illness _____ Y <input type="checkbox"/> N <input type="checkbox"/> Serious accident/injury _____ Y <input type="checkbox"/> N <input type="checkbox"/> Self harm _____	Y <input type="checkbox"/> N <input type="checkbox"/> Expulsion _____ Y <input type="checkbox"/> N <input type="checkbox"/> Incarceration _____ Y <input type="checkbox"/> N <input type="checkbox"/> 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 <input type="checkbox"/> NO <input type="checkbox"/>	
5. Please provide the name and <u>telephone &amp; fax #s</u> of your youth's therapist and/or prescribing physician:	
Therapist _____ Fax # _____	Telephone # _____ Email _____
Prescribing Physician _____ Fax # _____	Telephone # _____ Email _____

**Part III: Allergies, & Considerations**

**A. List Allergies**

<b>Allergy</b> (List Below)	<b>Reaction</b> (List Below)	<b>Treatment for Allergy</b> (if any)
Medications:		
Food:		
Insect bites/stings:		
Environmental (seasonal, dust, etc.):		

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

**A. Restrictions and other considerations**

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

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

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**Over-the-Counter Medication:**

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*You are responsible for listing only the over the counter medications your student may not take, in this section. 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 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.**

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

**Attach the full immunization records from your youth's pediatrician**

Or use the section below to complete.

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

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

phone \_\_\_\_\_

Name of dentist/orthodontist \_\_\_\_\_

phone \_\_\_\_\_

**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:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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 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: \_\_\_\_\_





# Christodora's Authorization to Administer Medication

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**Please list all medications that are prescription or over-the-counter and taken on a regular basis.** Medications must be in unexpired, original 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	<input type="checkbox"/> Oral <input type="checkbox"/> Topical	<input type="checkbox"/> Oral <input type="checkbox"/> Topical	<input type="checkbox"/> Oral <input type="checkbox"/> Topical	<input type="checkbox"/> Oral <input type="checkbox"/> 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**