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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.
  
2. **Parent/Guardian must complete all sections on Pages 1—5 plus page 7. Please do not leave any section blank.** Write "N/A" if a section does not apply to your child.
  - Page 1- Part I: General and Insurance Information
    - Fill in general information; check box about insurance info.
    - Attach a copy of front and back of insurance card.
    - **Sign and date** at the bottom of the page.
  - Page 2- Part II: Health History
    - Check boxes for Yes or No in every line and provide information for anything marked Yes.
  - Page 3- Medication and Mental Health questions
    - Check boxes for Yes or No.
  - Page 4- Part III: Allergies & Considerations
    - List allergies and physical reactions/treatments in section A
    - List Restrictions and other considerations (dietary, activity, etc.) in section B
  - Page 5- Part IV: Immunization History
    - All immunizations must be listed.
      - Complete the Immunization History on this form **OR Attach a copy** of the immunization records from your doctor.
  - Page 7- Christodora's Authorization to Administer Medication
    - List all medications that are prescription or over the counter AND taken on a regular basis (such as "daily") and enter information in each box. If your youth has an **epi-pen or asthma inhaler**, make sure you check the boxes at the bottom of Page 7.
    - **Sign and date** at the bottom of the page.
    - 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.

### **\*\*\* What does your doctor need to do?**

Your doctor (licensed medical provider) must review Pages 1-5 and complete, **sign, & date in the box at the bottom of Page 6 during your physical exam.** Their signature in the box indicates that your youth is able to participate in an active camp program.

**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.

# 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 18 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: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Male  Female  Non-binary

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:**

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 (check one):**

- YES** This youth takes medications.  
\*\*If YES you must complete the Authorization to Administer Medication on Page 7.
  
- NO** This youth takes NO medications & will not bring any medications to camp.  
\*\* If NO you do not need to complete Page 7.

**B. Mental Health**

<p>1. Has youth been diagnosed or treated for any of the following <u>currently</u> or within the <u>past year</u>?</p> <table style="width: 100%;"><tr><td style="width: 50%; vertical-align: top;"><p>Y <input type="checkbox"/> N <input type="checkbox"/> Attention Deficit Disorder (ADD)</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Adjustment Disorder</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Anxiety Disorder</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Disruptive Behavior Disorder</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Eating Disorder</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Impulse Control Disorder</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Learning Disorder</p></td><td style="width: 50%; vertical-align: top;"><p>Y <input type="checkbox"/> N <input type="checkbox"/> Developmentally Disabled</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Mood Disorder</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Personality Disorder</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Pervasive Developmental Disorder</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Substance Related Disorder</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Schizophrenia</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Other: _____</p></td></tr></table>	<p>Y <input type="checkbox"/> N <input type="checkbox"/> Attention Deficit Disorder (ADD)</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Adjustment Disorder</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Anxiety Disorder</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Disruptive Behavior Disorder</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Eating Disorder</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Impulse Control Disorder</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Learning Disorder</p>	<p>Y <input type="checkbox"/> N <input type="checkbox"/> Developmentally Disabled</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Mood Disorder</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Personality Disorder</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Pervasive Developmental Disorder</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Substance Related Disorder</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Schizophrenia</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Other: _____</p>
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<p>2. Has youth received treatment/therapy for any of the following, either <u>currently</u> or in the <u>past year</u>?</p> <table style="width: 100%;"><tr><td style="width: 50%; vertical-align: top;"><p>Y <input type="checkbox"/> N <input type="checkbox"/> Medication(s)</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Out Patient Counseling</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Day Treatment</p></td><td style="width: 50%; vertical-align: top;"><p>Y <input type="checkbox"/> N <input type="checkbox"/> Psychiatric Hospitalization</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Residential Treatment</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Personality Disorder</p></td></tr></table>	<p>Y <input type="checkbox"/> N <input type="checkbox"/> Medication(s)</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Out Patient Counseling</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Day Treatment</p>	<p>Y <input type="checkbox"/> N <input type="checkbox"/> Psychiatric Hospitalization</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Residential Treatment</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Personality Disorder</p>
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<p>3. Has youth experienced any of the following significant events within the <u>past year</u>? If yes, please explain:</p> <table style="width: 100%;"><tr><td style="width: 50%; vertical-align: top;"><p>Y <input type="checkbox"/> N <input type="checkbox"/> Serious Illness _____</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Serious accident/injury _____</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Self harm _____</p></td><td style="width: 50%; vertical-align: top;"><p>Y <input type="checkbox"/> N <input type="checkbox"/> Expulsion _____</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Incarceration _____</p><p>Y <input type="checkbox"/> N <input type="checkbox"/> Death of Family/Friend _____</p></td></tr></table>	<p>Y <input type="checkbox"/> N <input type="checkbox"/> Serious Illness _____</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Serious accident/injury _____</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Self harm _____</p>	<p>Y <input type="checkbox"/> N <input type="checkbox"/> Expulsion _____</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Incarceration _____</p> <p>Y <input type="checkbox"/> N <input type="checkbox"/> Death of Family/Friend _____</p>
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<p>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?      <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/></p>		
<p>5. Please provide the name and <u>telephone &amp; fax #s</u> of your youth's therapist and/or prescribing physician:</p> <table style="width: 100%;"><tr><td style="width: 50%; vertical-align: top;"><p><b>Therapist</b> _____</p><p><b>Fax #</b> _____</p> <p><b>Prescribing Physician</b> _____</p><p><b>Fax #</b> _____</p></td><td style="width: 50%; vertical-align: top;"><p><b>Telephone #</b> _____</p><p><b>Email</b> _____</p> <p><b>Telephone #</b> _____</p><p><b>Email</b> _____</p></td></tr></table>	<p><b>Therapist</b> _____</p> <p><b>Fax #</b> _____</p> <p><b>Prescribing Physician</b> _____</p> <p><b>Fax #</b> _____</p>	<p><b>Telephone #</b> _____</p> <p><b>Email</b> _____</p> <p><b>Telephone #</b> _____</p> <p><b>Email</b> _____</p>
<p><b>Therapist</b> _____</p> <p><b>Fax #</b> _____</p> <p><b>Prescribing Physician</b> _____</p> <p><b>Fax #</b> _____</p>	<p><b>Telephone #</b> _____</p> <p><b>Email</b> _____</p> <p><b>Telephone #</b> _____</p> <p><b>Email</b> _____</p>	

**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.**

**B. 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, behavioral) that you feel the camp should be aware of and may assist us in providing safe and beneficial participation in the program.

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**Part IV: Immunization History – (required for admittance 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>						Hepatitis C	
TD (tetanus/diphtheria)						Measles	
Tetanus						Chicken pox	
Polio						German measles	
<b>MMR*</b>						Mumps	
Or measles						Hepatitis A	
Or mumps						Hepatitis B	
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 the health history.  
By my signature, the above person is able to participate in our 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:** \_\_\_\_\_



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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 packaging (not in pill boxes, ziplock bags, etc.). Please do not list of send over-the-counter medications that your child may take on an “as-needed” basis.

**Youth Name** \_\_\_\_\_

I understand that Christodora---Manice Education Center does not assume responsibility for any medication that I 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				
Special Storage Requirements				

**AUTHORIZATION:**

I hereby authorize the health care consultant or properly trained health care supervisor at Christodora to administer, to my child, \_\_\_\_\_ the medication(s) listed above, in accordance with 105 CMR 430.160(C) and \_\_\_\_\_ (name of camper) 105 CMR 430.160(D) [see below].

**If above listed medication includes epinephrine injection system:**  
 I hereby authorize my child to self-administer , with approval of the health care consultant  Yes  No  Not Applicable  
 I hereby authorize an employee that has received training in allergy awareness and epinephrine administration to administer  Yes  No  Not Applicable

**If above listed medication includes a metered dosed inhaler:**  
 I hereby authorize my child to carry and administer his/her own metered does inhaler(s) as prescribed by a licensed health care professional.  Yes  No  Not Applicable

**If above listed medication includes insulin for diabetic management:**  
 I hereby authorize my child to self-administer , with approval of the health care consultant  Yes  No  Not Applicable

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



## **Authorization to Administer Medication Information**

\*\* **Health Care Consultant** at a recreational camp is a Massachusetts licensed physician, certified nurse practitioner, or a physician assistant with documented pediatric training. **Health Care Supervisor** is a staff person of a recreational camp for children who is 18 years old or older; is responsible for the day to day operation of the health program or component, and is a Massachusetts licensed physician, physician assistant, certified nurse practitioner, registered nurse, licensed practical nurse, or other person specially trained in first aid.

**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. **(M.G.L. c. 94C § 21).**

**105 CMR 430.160(C):** Medication shall only be administered by the health care supervisor or by a licensed health care professional authorized to administer prescription medications. If the health care 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):** A written policy for the administration of medications at the camp shall identify the individuals who will administer medications. This policy shall:

(1) List individuals at the camp authorized by scope of practice (such as licensed nurses) to administer medications; and/or other individuals qualified as health care supervisors who are properly trained or instructed, and designated to administer oral or topical medications by the health care consultant.

(2) Require health care supervisors designated to administer prescription medications to be trained or instructed by the health care consultant to administer oral or topical medications.

(3) Document the circumstances in which a camper, Health Care Supervisor, or Other Employee may administer epinephrine injections. A camper prescribed an epinephrine auto-injector for a known allergy or pre-existing medical condition may:

a) Self-administer and carry an epinephrine auto-injector with him or her at all times for the purposes of self-administration if:

1) the camper is capable of self-administration; and

2) the health care consultant and camper's parent/guardian have given written approval.

(b) Receive an epinephrine auto-injection by someone other than the Health Care Consultant or person who may give injections within their scope of practice if:

1) the health care consultant and camper's parent/guardian have given written approval; and

2) the health care supervisor or employee has completed a training developed by the camp's health care consultant in accordance with the requirements in 105 CMR 430.160.

(4) Document the circumstances in which a camper may self-administer insulin injections. If a diabetic child requires his or her blood sugar be monitored, or requires insulin injections, and the parent or guardian and the camp health care consultant give written approval, the camper, who is capable, may be allowed to self-monitor and/or self-inject himself or herself. Blood monitoring activities such as insulin pump calibration, etc. and self-injection must take place in the presence of the properly trained health care supervisor who may support the child's process of self-administration.

**105 CMR 430.160(F):** The camp shall dispose of any hypodermic needles and syringes or any other medical waste in accordance with 105 CMR 480.000: Minimum Requirements for the Management of Medical or Biological Waste.

**105 CMR 430.160(I):** When no longer needed, medications shall be returned to a parent or guardian whenever possible. If the medication cannot be returned, it shall be disposed of as follows:

(1) Prescription medication shall be properly disposed of in accordance with state and federal laws and such disposal shall be documented in writing in a medication disposal log.

(2) The medication disposal log shall be maintained for at least three years following the date of the last entry.