CAMP TEKAKWITHA

• EST 1926 •

CHAPERONE NAME: _____ DATE OF BIRTH:_____

RETREAT GROUP: _____

HEALTH HISTORY

1. **Physical Conditions or Limitations** – Please circle any of the following that your child has had/been:
   a. Hospitalized
   b. Surgery
   c. Recurrent/chronic illnesses
   d. Recent infectious disease
   e. Injury
   f. Asthma/wheezing/shortness of breath
   g. Diabetes
   h. Seizures
   i. Headaches
   j. Glasses, contacts, or protective eyewear
   k. Fainting or dizziness
   l. Passed out/chest pain during exercise
   m. Mononucleosis (mono) in the last 12 months
   n. Females – problems with periods/menstruation
   o. Falling asleep/sleepwalking
   p. Back/joint pain
   q. Bedwetting
   r. Diarrhea/constipation
   s. Skin problems
   t. Mental/Emotional concerns that could impact your duties as chaperone.

Please explain any of the circled conditions or limitations:

Are there any Camp activities that you are unable to participate in due to health reasons?

2. Medications

Name of medication	Date started	Reason for taking it	When it is given	Amount or does given	How it is given

Please note here any medications you are taking that would impair your ability to perform the essential functions as a chaperone:_____

HEALTH HISTORY (cont.)

3. **Allergies** – please list all known allergies and reaction seen

4. **Immunization Status** – Doses in Month/Year
   a. Diptheria, tetanus, pertussis (DTaP) or (TdaP)_____
   b. Tetanus bosster (dT) or (TdaP) _____
   c. Mumps, measles, rubella (MMR) _____
   d. Polio (IPV) _____
   e. Haemophilus influenzae type B (HIB) _____
   f. Pneumococcal (PCV) _____
   g. Hepatitis B _____
   h. Hepatitis A _____
   i. Varicella (chicken pox) _____
   j. Meningococcal meningitis (MCV4) _____
   k. Tuberculosis (TB) test _____

5. **Emergency Contact Information** – Please list who we should contact in the case of an emergency:
   Name: _____ Phone Number: _____
   Relation to you: _____
   Name: _____ Phone Number: _____
   Relation to you: _____

6. **Permission to Treat**
   I hereby give permission to the medical personnel selected by Camp Tekakwitha's director to provide routine health care; to administer prescribed medications; and to administer emergency treatment for me/my child, including, but not limited to X-rays, routine tests and treatment and/or hospitalization; and to provide or arrange necessary related transportation for me/my child. I also agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

   If the person named herein is a minor, it is my intention that representatives of the camp be considered 'personal representatives' for the purpose of disclosing health information that is protected under the Health Insurance Portability and Accountability Act of 1996. I also agree to the disclosure to camp representatives of protected health information of the person named herein in order to provide information related to the person's ability to participate in camp activities; and if the person named herein is a minor, to provide information to the camp representatives to keep me informed of my child's health situation.

   In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the named person.
   Signature: _____ Date: _____

Chaperone Name: _____ Date Completed: _____
Phone Number(s): _____