Diocese of the Northeast ACA
Health History and Medical Examination Form for Minors

Health History: Please provide complete information so we can provide the care your child needs.
Medical Examination: A medical examination is required. The examination must be completed by a licensed physician, nurse practitioner, physician's assistant or registered nurse within the preceding 24 months unless a health issue is present.

Please type or write clearly and legibly.

Name of Minor: (Last, First, Middle Initial)	**Date of Birth**: (XX/XX/XXXX)		
Address:	**City:**	**St:**	**Zip:**
Parent or Guardian:	**Phone:**	**Alternate Phone:**	
Parent or Guardian:	**Phone:**	**Alternate Phone:**	

Emergency Contact Information (parent/guardian):

Emergency Contact:	**Relationship:**
Phone:	**Alternate Phone:**

Health Insurance Information

Policy Holder's Name:	**Policy Number:**
Insurance Company Name:	**Group Number:**
Insurance Company Address:	**Insurance Company Phone:**

Check all that apply and explain in detail checked answers:

☐	Diabetes	☐	Sleep disturbances
☐	Heart Defects/Disease	☐	Fainting
☐	Asthma	☐	Bed wetting
☐	Ear Infections	☐	Constipation
☐	Musculoskeletal Disorders	☐	Chicken Pox
☐	Convulsions/Epilepsy/Seizures	☐	Measles
☐	Sinusitis (Sinus Infections)	☐	German Measles
☐	Physical Restrictions	☐	Mumps
☐	Kidney/bladder illness	☐	Rheumatic Fever
☐	Mental/psychological disorder	☐	Tuberculosis
☐	Hypertension	☐	Kidney Disease
☐	Arthritis	☐	Eating Disorders (Anorexia, Bulimia, etc.)
☐	Nosebleeds	☐	Headaches/Migraines
☐	Has begun menstruation	☐	Had surgery or hospitalized in the last 5 years
☐	Menstrual cramps	☐	Currently under doctor's care
☐	Bleeding disorder	☐	Emotional – Separation Anxiety
☐	Other:		

Please explain in detail all checked answers marked above:

Child Name: ____

Allergies: Please list all allergies, the type of reaction and its severity, treatment and date of last reaction. Include allergies to medications, food, bees, animals, plants, etc.

Allergies	Reaction/ Severity	Treatment	Date of last Reaction
1.			
2.			
3.			

Does this child suffer from Anaphylaxis? Yes No
*Anaphylaxis is a severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.
Does your child carry an Epipen? Yes No

Does your child carry an inhaler? Yes No

Medical Conditions (including any precautions or restrictions on activities)

Name of Condition	Effects
1.	
2.	
3.	

Medications: List any medications child is currently taking (or has taken in the recent past) including dosage schedule and specific instructions for use. Also, please indicate (Yes/No) if minor is allowed to take the medication on their own or if they should be monitored by an advisor. This would include any type of birth control.

Medication	Purpose	Dosage Schedule	Specific Instructions	Self-Medicate? (Yes/No)
1.				
2.				
3.				
4.				
5.				

Over-the-Counter Medications: This child has permission to take over-the-counter medications in case of accident or injury. Please check all that she has permission to take:

- ☐ Tylenol/Acetaminophen
- ☐ Aspirin (fever reducer)
- ☐ Ibuprofen (pain/swelling)
- ☐ Benadryl/Antihistamine
- ☐ Robitussin/expectorant
- ☐ Sudafed/decongestant
- ☐ Pepto Bismol
- ☐ Tums/antacid
- ☐ Imodium (anti-diarrhea)
- ☐ Dramamine (motion sickness prevention)
- ☐ Skin Ointments (in case of rash, antibacterial, athlete's foot, etc.)
- ☐ Other: ____
- ☐ Other: ____

Special considerations or notes regarding over-the-counter medications:

Does your child have a Special Medical or Dietary Regiment to be followed? Yes No
If so, please explain: ____________________

Has this child ever had any adverse reactions to general anesthetics? Yes No
If so, please explain: ____________________

Any other information not covered in this form that is important for staff to know: ____________________
____

Child Name: ____________________ **Date:** __________
(This section is to be completed by a physician after the review of health history with parent/guardian. Parent/Guardian must complete all the information of the Health History to the best of their knowledge and sign before meeting with licensed professional.)

Medical Examination – Must be completed in detail.

Height: ______ Weight: ______ B. P.: _____/_____ Hearing: R ___ L ___
Eyes: With Glasses R 20/______ L 20/______ Without Glasses R 20/______ L 20/_______
Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined

________ Nose	________ Abdomen	________ Urinalysis*	Other: __________
________ Throat	________ Hernia	________ HGB*	__________
________ Teeth	________ Genitalia	________ Appearance/Nutrition	__________
________ Heart	________ Skin	________ General Physical State	__________

Record of Immunization – Must be completed in detail.

	Date Series was Completed	Year of Last Booster		Date Series was Completed	Year of Last Booster
Hep B	________	________	Typhoid	________	________
DTap/Tdap	________	________	Paratyphoid	________	________
DT/Td	________	________	Cholera	________	________
Hib	________	________	Yellow Fever	________	________
IPV/OPV	________	________	Typhus	________	________
PCV7	________	________	Rocky Mountain		
MMR	________	________	Spotted Fever	________	________
Varicella	________	________	Tuberculin Test: Year last given	________	Result ________
Other:			Not required immunizations, but recommended		
________	________	________	HPV	________	________
________	________	________	Rota	________	________
________	________	________	MCV4/MPSV4	________	________
________	________	________	Hep A	________	________
________	________	________	TIV/LAIV	________	________

Personal and religious beliefs dictate against immunizations: Yes No

Physician Information

Licensed Physician Name: (Last, First, Middle Initial)	**Phone Number:**		
Address:	**City:**	**St:**	**Zip:**

This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities except as noted.

Signature of Licensed Physician: ____________________ **State License Number:** ________ **Date:** ________

HEALTH INFORMATION PRIVACY STATEMENT

The **Health History and Medical Examination Form for Minors** is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor for the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. This form will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative. I have read the above procedures for handling the health and medical form and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

This Health History and Medical Examination Form for Minors is complete and accurate. My child has permission to engage in all prescribed activities, except as noted by me and the examining physician.

Signature of Parent/Guardian: ____ Date: __________________________

General Liability Release

My child may have sunscreen and/or insect repellent applied to exposed areas of his/her skin before going outside at the discretion of the Anglican Church in America Diocese of the Northeast and its staff.

I give permission for my child to be photographed, video recorded and/or audio recorded during camp and any videos, photos and/or recordings in which my child appears, and/or audio recordings made of his/her voice may be used by Anglican Church in America, its assigns or successors, in whatever way they desire, including television, print material and electronic media, including, but not limited to internet websites. Furthermore, I hereby consent that such photos, videos and recordings, and the devices from which they are made shall be their property, and they shall have the right to duplicate, reproduce, and make other uses of such photos, videos, and recordings of any type as they may desire free and clear of any claim whatever on my part.

My child may fully participate in all recreational activities during Summer Camp, including but not limited to: sports, swimming, hiking, and boating. I acknowledge and agree that the risk of injury from participation involved in such activities is significant, including the potential for permanent disability and death. And while direct supervision, protective equipment and personal discipline will minimize this risk, the risk of serious injury does exist. I knowingly and freely assume all such risks, both known and unknown, even arising from the negligence of those persons released from liability below, and assume full responsibility for my child's participation. I understand that participation in such activities is physically and mentally intense. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, hereby release and hold harmless, The Anglican Church in America, Diocese of the Northeast and its staff, its assigns or successors with respect to any and all injury, disability, death, or loss or damage to person or property, whether caused by the negligence of the releasees or otherwise, except that which is the result of gross negligence and/or wanton misconduct.

I give permission for my child to be given emergency treatment by staff members at the Anglican Church in America Diocese of the Northeast Youth Camp, and give permission for my child to be transported to an emergency center for treatment if necessary, and I hold the Anglican Church in America Diocese of the Northeast and its staff harmless in the event that treatment and/or transportation becomes necessary. In the event that I cannot be contacted immediately, medical or surgical treatment may be administered to my child in the case of an accident or emergency, as prescribed by a treating physician, and I hold the Anglican Church in America Diocese of the Northeast and its staff harmless. I agree that I will be responsible for any and all cost related to any and all medical treatment of my child during summer camp.

I hereby acknowledge and agree that any child of mine whom I send to St. Luke's Camp is to be under the authority of the camp director and staff while there. I have gone over the current guidelines and my child and we fully understand and accept them and any further rules or decisions made by the camp director or staff that will in their opinion provide for a better camp experience will be followed. We do not expect there to be any discipline problems, but if the camp staff feels for any reason my child is a potential problem I agree that my child may be isolated for the protection of others, and I further agree to come and pick up my child as quickly as I can if the staff or director informs me that they feel it is necessary. If it is necessary for my child to leave camp early, I agree that the Diocese of the Northeast, ACA, and the summer camp staff will have no liability beyond a prorated refund of the camp fee, with priority given to refunding any donor which may have helped pay for my child's attendance.

I have discussed with my child in a way appropriate to my child's age the need to wear modest clothing and behave properly at camp. My child and I have discussed proper hygiene and agree that washing and other practices will be done without hassle in a manner that promotes good hygiene.

I have given valid contact information on my forms and will be available at the phone numbers I have given. Further, my child and I understand that no advances of a romantic nature are to be pursued or encouraged at camp, and will be grounds for immediate and possibly permanent removal from any ACA camping program.

I have completely read and understand this release of liability and assumption of risk agreement.

Name of child____

X____date___________________X____date_________________

parent/guardian parent/guardian

Please ensure that you fill out <u>each of these form completely</u>, and promptly return them with your $100 down payment per child to:

Father Rich Dibble
ACA/DNE Camp Director
10265 US Route 20
West Winfield, NY 13491