THIS FORM IS FOR: Last Name:_____ First Name: _____ Date of Birth: _____

2024 Health History to be filled out by Parent or Guardian (page 1 of 4)

Basic Contact Information

Rally Participant's Information

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth:_____ Age when at Rally:_____ Gender *(circle one)* Male *or* Female

Address:_____City:_____

Zip Code:_____ Phone Number:_____ Additional Phone Number(s):_____

Parent or Guardian's Information (Emergency Contact #1) How Related to Rally Participant: _____

Last Name: _____ First Name: _____ Middle Name: _____

Address:_____City:_____

Zip Code:_____ Phone Number:_____ Additional Phone Number(s):_____

Second Parent or Second Guardian's Information (Emergency Contact #2) How Related to Rally Participant: _____

Last Name: _____ First Name: _____ Middle Name: _____

Address:_____City:_____

Zip Code:_____ Phone Number:_____ Additional Phone Number(s):_____

Emergency Contact # 3 (In addition to the Parents/Guardians listed above.) How Related to Rally Participant: _____

Last Name: _____ First Name: _____ Middle Name: _____

Address:_____City:_____

Zip Code:_____ Phone Number:_____ Additional Phone Number(s):_____

IMPORTANT: If you are traveling or on vacation while your child is at Youth Rally, please indicate how we may contact you:_____

_____

Insurance Information

Carrier or Plan Name:_____ **Group #:**_____

IMPORTANT: You must send us a copy your child's health insurance card, front and back!!!

You are responsible for any incurred medical expenses. If you need pre-approval for out-of-plan services, it is your responsibility to notify your insurance provider.

Licensed Medical Professional/Provider Information

Name of Rally Participant's Primary Care Physician: _____ Office Phone Number: _____

Address:_____

Name of Rally Participant's Dentist/Orthodontist: _____ Office Phone Number: _____

Address:_____

2024 Health History to be filled out by Parent or Guardian (page 2 of 4)

Permission to Treat, Medical Release and Acknowledgement of Financial Responsibility

Parent/Guardian Authorizations:

The health history in this form is correct and complete as far as I know. The person herein named (i.e., the person for whom this form is being filled out, also referred to herein as "my child") has permission to engage in all camp activities except as noted.

I hereby give permission to the camp (i.e., the Diocese of New England Youth Rally) to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* inasmuch as the person herein named is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representatives" for the purposes of disclosing Protected Health Information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996.

I hereby agree to the disclosure to camp representatives of the Protected Health Information of the person herein described, as necessary: (i) To provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

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

As stated above, I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I will assume financial responsibility for any services provided by the treating physician or hospital not paid by my insurance company for any reason.

This completed form may be copied (photocopied, scanned, photographed, imaged, etc.) for use away from camp.

I give permission for my child to be given the Over-the-Counter (OTC) medications listed below (or the generic equivalents), if needed, while at camp. Doses are to be administered as per package directions. I have crossed off any medications that I do not want my child to be given.

Over-the-Counter (OTC) Medication Regulations

Acetominophen
Antifungal powder or cream
Aurogan (for ear pain)
Bacitracin
Balmex
Calamine/Caladryl Lotion
Cough Drops
Diphenhydramine (Benadryl)
Epinephrine for treatment of anaphylaxis (epi pen)
Hydrocortisone Cream
Ibuprofen (Motrin, Advil)
Imodium
Loratadine (Claritin)
Milk of Magnesia
Phenylephrine (Sudafed PE)
Pseudoephedrine (Sudafed)
Robitussin
Robitussin DM
Sore Throat Lozenges
Tums
Zyrtec

With my signature I agree to the above parent/guardian authorizations and give my child permission to participate in all Youth Rally activities and programs.

My child's name is:_____

Signature of Parent/Guardian: _____ Relationship to Rally participant: _____

Printed Name of Parent/Guardian: _____ Date Signed: _____

THIS FORM IS FOR: Last Name:_____ First Name: _____ Date of Birth: _____

2024 Health History to be filled out by Parent or Guardian (page 3 of 4)

Allergies	**Reaction**	**Treatment**
Food Allergies_____	_____	_____
_____	_____	_____
_____	_____	_____
Medication Allergies_____	_____	_____
_____	_____	_____
_____	_____	_____
Other Allergies (Insect Stings, hay fever, environmental, dander, etc.)_____	_____	_____
_____	_____	_____
_____	_____	_____

Explain Any Restrictions to Activity (For example, what cannot be done, what adaptations or limitations are necessary) _____

_____

_____

Dietary Restrictions/Choices ***(circle/check those that apply)***

[ ] Does not eat red meat [ ] Does not eat poultry [ ] Does not eat pork [ ] Does not eat eggs [ ] Does not eat dairy products [ ] Lactose Intolerant

[ ] Does not eat fish [ ] Does not eat shellfish [ ] Other *(please specify)*:_____

General Questions ***(Please explain any YES answers below.)***

Has or does the person for whom this form is being filled out…

1) …had any recent injury, illness or infectious disease? [ ] No [ ] Yes
2) …have any chronic or reoccurring illness or condition? [ ] No [ ] Yes
3) …ever been hospitalized? [ ] No [ ] Yes
4) …have frequent headaches? [ ] No [ ] Yes
5) …ever had surgery? [ ] No [ ] Yes
6) …ever had a head injury or been knocked unconscious? [ ] No [ ] Yes
7) …wear glasses, contacts or protective eye wear? [ ] No [ ] Yes
8) …ever had frequent ear infections? [ ] No [ ] Yes
9) …ever had fainting or dizziness? [ ] No [ ] Yes
10) …ever had seizures? [ ] No [ ] Yes
11) …ever had chest pain or passed out during or after exercise? [ ] No [ ] Yes
12) …ever had high blood pressure? [ ] No [ ] Yes
13) …ever been diagnosed with a heart defect/disease (heart murmur, etc.)? [ ] No [ ] Yes
14) …ever suffered from a bleeding or clotting disorders? [ ] No [ ] Yes
15) …ever had back problems? [ ] No [ ] Yes
16) …ever had problems with joints (knees, ankles, etc.)? [ ] No [ ] Yes
17) …ever suffered a bone fracture? [ ] No [ ] Yes
18) …have an orthodontic appliance being brought to camp? [ ] No [ ] Yes
19) …have any skin problems? [ ] No [ ] Yes
20) …have diabetes? [ ] No [ ] Yes
21) …have asthma, wheezing or shortness of breath? [ ] No [ ] Yes
22) …had mononucleosis within the past 12 months? [ ] No [ ] Yes
23) …had problems with diarrhea or constipation? [ ] No [ ] Yes
24) …Had problems with frequent stomachaches? [ ] No [ ] Yes
25) …have problems with falling asleep or sleep walking? [ ] No [ ] Yes
26) …if female, have an abnormal menstrual history? [ ] No [ ] Yes
27) …have a history of bed wetting? [ ] No [ ] Yes
28) …ever had an eating disorder? [ ] No [ ] Yes
29) …ever been treated for an attention deficit disorder such as ADD or AD/HD? [ ] No [ ] Yes
30) …ever experienced homesickness? [ ] No [ ] Yes
31) …travelled out of the country in the last 9 months? [ ] No [ ] Yes
32) …ever been treated for emotional or behavioral difficulties? [ ] No [ ] Yes
33) …had a life event that continues to affect his or her life? [ ] No [ ] Yes

Please explain any **YES** answers to above questions (attach additional pages if necessary):_____

_____

_____

_____

Please give further information concerning behavior and physical, emotional or mental health of which the Rally staff should be aware (attach additional pages if necessary):_____

_____

_____

_____

_____

Youth Rally of the Diocese of New England of the Orthodox Church in America ~ Fr. Moses Locke, Director
Director's Office: 1070 Roxbury Road, Southbury, CT 06488
Email: youthrally@dneoca.org ~ Telephone: 630-832-6791

THIS FORM IS FOR: Last Name:_____ First Name: _____ Date of Birth: _____

2024 Health History to be filled out by Parent or Guardian (page 4 of 4)

Signature of Parent/Guardian

The information presented in this four-page long Health History (both coming before and following below this signature block) is correct and complete to the best of my knowledge at the time of its signing. My child has permission to engage in all prescribed camp activities except as noted. I have indicated any and all special health conditions, including required medication and activity limitations that should be known to the Rally staff and Rally medical personnel. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury.

Signature: _____ Date Signed: _____

Printed Name:_____ Relationship to Rally participant: _____

Medications

Will the Rally participant for whom this form is being filled out be using medications (prescription OR non-prescription) while at Youth Rally?

[ ] Yes **[ ] No**

If a Rally participant will be using ("taking") medication(s) while at Youth Rally, he or she must have consent of his or her parent or legal guardian for those meds to be distributed to him or her by the Rally Medical staff. Please list here **every medication** of every type (prescription meds, over-the-counter meds, vitamins, supplements, etc.) or form (tablets, crèmes, lotions, syrups, mists, etc.) that your Rally participant will be bringing to rally in order to use ("take") at Rally. Medical devices that are being brought to Rally must be listed below in the manner of medications. **Use an additional copy of this sheet if necessary, signed and dated appropriately.** *(SIGN THIS PAGE AT THE TOP TO VALIDATE IT!!!)*

Name of Medication: ***(print clearly and legibly!)***

_____

Check [x] all boxes that apply to this medication

[ ] Prescription Medication [ ] Over-the-Counter Medication [ ] Vitamin or Supplement [ ] Taken on a routine basis [ ] Taken on an as-need basis

[ ] Prescribed for a chronic illness or condition [ ] Epi-Pen held on person [ ] Inhaler held on person

Complete below as per original container's label:

Dosage: _____ Frequency: _____ Expiration Date: _____

Purpose: _____

Name of Prescribing Licensed Medical Professional: _____ Phone number of Prescriber: _____

Comments: _____

Name of Medication: ***(print clearly and legibly!)***

_____

Check [x] all boxes that apply to this medication

[ ] Prescription Medication [ ] Over-the-Counter Medication [ ] Vitamin or Supplement [ ] Taken on a routine basis [ ] Taken on an as-need basis

[ ] Prescribed for a chronic illness or condition [ ] Epi-Pen held on person [ ] Inhaler held on person

Complete below as per original container's label:

Dosage: _____ Frequency: _____ Expiration Date: _____

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Name of Prescribing Licensed Medical Professional: _____ Phone number of Prescriber: _____

Comments: _____

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THIS FORM IS FOR: Last Name:_____ First Name: _____ Date of Birth: _____

Record of Health Exam by Licensed Medical Provider, (page 1 of 1)

Date of Last Examination: _____ (The exam referenced on this form must have taken place within the last two years! No exceptions!)

Blood Pressure: _____ Weight:_____ Height:_____

In my opinion, the above named person [ ] IS [ ] IS NOT able to participate in an active camp program.

The above named person is under the care of a physician for the following conditions (attach additional pages if necessary): _____

_____

In addition to the above, this is medical information about the above named person that is pertinent to routine care and emergencies (attach additional pages if necessary):

_____

Experience and/or Occurrence of Disease The above named person has had:

[ ] Measles [ ] Chicken Pox [ ] German Measles/Rubella [ ] Mumps [ ] Hepatitis (A, B, or C ?) [ ] Tuberculosis

[ ] TB Mantoux Test Date of Last Test: _____ Result of Test: [ ] Positive [ ] Negative

Immunization Dates	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year	Month/Year
DPT	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____	_____
Varicella	_____	_____	_____	_____	_____	_____

Recommendations and Restrictions at Camp

Treatment to be continued at camp: _____

_____

Medications (Prescription and/or OTC) to be administered at Camp (Name, Dosage, Frequency): *[Please attach additional pages if necessary]*

*Med :*_____*Dosage:*_____*Frequency:* _____

*Med :*_____*Dosage:*_____*Frequency:* _____

*Med :*_____*Dosage:*_____*Frequency:* _____

Any medically-prescribed meal plan or dietary restrictions: _____

_____

Known Allergies: _____

_____

Description of any limitations on or restrictions of camp activities: _____

_____

Signature of Licensed Medical Provider

The information presented on this Record of Health Examination (the above page) is correct and complete to the best of my knowledge at the time of its signing.

Signature: _____ Date Signed: _____

Printed Name:_____ Title _____

Address:_____

City:_____ Zip Code:_____ Phone Number:_____

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THIS FORM IS FOR: Last Name:_____ First Name: _____ Date of Birth: _____

PERMISSION FOR POSSESSION AND USE OF EPINEPHRINE AUTO-INJECTORS ("EPI-PEN") AND ASTHMA INHALERS

IMPORTANT NOTE: This form is in addition to the health form!

In order to comply with NH RSA 485 (New Hampshire Revised Statutes Annotated 485), ***your physician must complete and sign this form*** which allows your child to possess epi-pens or inhalers on their person while at camp. In accordance with RSA 485 your child will not be allowed to keep epi-pens or inhalers on their person without this completed form.

NOTE: Your child will need an additional inhaler/epi-pen to be stored in the camp infirmary in case of emergency. *(NH RSA485-A:25-d Availability)*

Camper Name_____

Home Address_____

Please circle appropriate action: Asthma Inhaler Epi-pen

Name of Licensed Prescriber_____

Business phone #_____ Emergency phone #_____

Please describe the medication:

Name _____ Date of Order_____

Route_____ Dosage_____

Frequency and time of administration_____

Please provide a diagnosis and describe any other medical condition requiring medication (if not a violation of confidentiality)

_____

_____

Please name any additional medications _____

Specific recommendations for administration _____

Are there any special side effects, contraindications, or adverse reactions to be observed?_____

_____

Are there any severe reactions that could occur to another child for whom the medication is not prescribed, should such a child receive a dose of medication?

_____

_____

I certify that _____has a valid prescription, and the skills and knowledge to safely possess and use an epi-pen/asthma inhaler while in a camp setting.

Physician Name_____

Physician Signature_____ Date Signed:_____

Campers must report to nurse immediately after using the epinephrine auto-injector!

Permission is given to the Diocese of New England Youth Rally to allow my child to possess and use an epi-pen/asthma inhaler while at Rally.

Parent Signature_____ Date Signed:_____

Name of Parent (printed legibly):_____

NH RSA 485-A: 25-e & g Immunity. No recreational camp or camp employee shall be liable in a suit for damages as a result of any act or omission related to a child's use of an epinephrine auto-injector or inhaler if the provisions of RSA 485 have been met.

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THIS FORM IS FOR: Last Name:________________________ First Name: __________________________ Date of Birth: __________________

Please Mail this Form With the Rest

(Use as many copies of this form as necessary—many meds will require many forms!)

Medication Form Medication Form Medication Form

This medication form is an inventory of **every medication** of every type (prescription meds, over-the-counter meds, vitamins, supplements, etc.) or form (tablets, crèmes, lotions, syrups, mists, etc.) that your Rally participant is bringing to Youth Rally. All of these medications are to be placed inside one clear plastic zip-lock bag, labeled with your Rally participant's full name and date of birth. **All medications must be in original packaging with all labeling intact and legible.**

The meds you list on this form must coincide with the meds in the bag. The meds you list on this form should match what you listed on the Rally Medical Form that you submitted by mail earlier; if there are any discrepancies, please, do include a note explaining those differences.

Affirmation and Signature: I have read the above instructions in full: I understand those instructions and am endeavoring to fulfill them as I complete this form.

Signature of Person filling out this form: ____ Date signed: ____

Printed Name of the Person filling out this form: ________________________________ Relationship to Person for whom this form is being filled out:______________________

Name of Medication: ***(print clearly and legibly!)***

____

Check [x] all boxes that apply to this medication

[ ] Prescription Medication [ ] Over-the-Counter Medication [ ] Vitamin or Supplement [ ] Taken on a routine basis [ ] Taken on an as-need basis

[ ] Prescribed for a chronic illness or condition [ ] Epi-Pen held on person [ ] Inhaler held on person

Complete below as per original container's label:

Dosage: ____ Frequency: ____ Expiration Date: ____________________

Purpose: ____

Name of Prescribing Licensed Medical Professional: ___________________________________ Phone number of Prescriber: ____

Comments: ____

Name of Medication: ***(print clearly and legibly!)***

____

Check [x] all boxes that apply to this medication

[ ] Prescription Medication [ ] Over-the-Counter Medication [ ] Vitamin or Supplement [ ] Taken on a routine basis [ ] Taken on an as-need basis

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Name of Medication: ***(print clearly and legibly!)***

____

Check [x] all boxes that apply to this medication

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