

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: _____

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

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

Acetaminophen

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: _____

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: _____

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

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 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 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: _____

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: _____

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: _____

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: _____

**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.

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: _____

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 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: _____

Purpose: _____

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

Comments: _____

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: _____