



**Youth Ministry Office
Episcopal Diocese of Pennsylvania**

**Health History and Examination Form
for Children, Youth and Adults Attending Three Day or Longer
Extended Mission Trips, Camp, Conferences and Events**

FOR PARISH AND DIOCESAN USE

**Episcopal Diocese of Pennsylvania
Youth Ministry Office
Attn: Andrew Kellner
240 South Fourth Street
Philadelphia, PA 19106
PHONE: 215/627-6434x120
EMAIL: andrewk@diopa.org
www.diopa.org**

The information on this form is not part of the participant acceptance process, but is gathered to assist us in identifying the appropriate care. This form, except for the Health Recommendations of Licensed Medical Personnel, is to be completed by the custodial parent/guardian in the case of a minor, or by adults for themselves. **Any general physical examination completed two years prior to the end date the trip by a licensed medical professional, can be applied to this form.**

PARTICIPANT NAME _____
Last First Middle

PRIMARY ADDRESS _____
Street City State ZIP

SOCIAL SECURITY NUMBER _____
Participant

GENDER:	<input type="checkbox"/> FEMALE	<input type="checkbox"/> MALE
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CUSTODIAL PARENT/GUARDIAN _____ **PRIMARY PHONE** _____

HOME ADDRESS _____
(If different from above) Street City State ZIP

BUSINESS ADDRESS _____ **WORK PHONE** _____

**SECONDARY PARENT/
GUARDIAN/EMERGENCY CONTACT NAME** _____
First Home

ADDRESS _____
(If different from above) Street City State ZIP

BUSINESS ADDRESS _____ **WORK PHONE** _____

IF NOT AVAILABLE IN AN EMERGENCY, PLEASE NOTIFY:

NAME _____

RELATIONSHIP _____ **PRIMARY PHONE** _____

ADDRESS _____

INSURANCE INFORMATION:

IS THE PARTICIPANT COVERED BY FAMILY MEDICAL/ HOSPITAL INSURANCE? _____
(Yes or No)

IF SO, INDICATE CARRIER or PLAN NAME _____ **GROUP #** _____

CARRIER ADDRESS _____

NAME OF INSURED _____

SOCIAL SECURITY NUMBER OF POLICY HOLDER OR INSURANCE ID NUMBER _____

Youth/Adult Participant Agreement*:

I agree to abide by all restrictions placed on my participation in activities by the "participant medically exempt from below activities" category of this form.

Signature of Youth/Adult Participant _____ **Date** ____/____/____

**Mandatory for Attendance*

Parent/Guardian or Adult Participant Authorizations*

This health history is correct and complete to the best of my knowledge. The person here in described has permission to engage in all activities except those noted in the "participant medically exempt from below activities" category of this form.

I hereby give permission to the Episcopal Diocese of Pennsylvania or the Episcopal Church program to provide routine health care, administer all prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I also give permission to the Episcopal Diocese of Pennsylvania or the Episcopal Church to arrange necessary related transportation for me/my child.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Episcopal Diocese of Pennsylvania or the Episcopal Church to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for any trips or transportation affiliated with the Episcopal Diocese of Pennsylvania or the Episcopal Church program.

Signature of Parent/Guardian or Adult Participant _____ **Date** ____/____/____

Full Printed Name of the Above Signer _____
First Middle Last

**Mandatory for Attendance*

Health History:

The following information *must* be completed by the parent/guardian. This information will supply the Episcopal Diocese of Pennsylvania or the Episcopal Church program health care personnel with the necessary background information to provide the appropriate medical care to the participant. Keep a copy of the completed form for your records. Any changes to this form *must* be provided to the Episcopal Diocese of Pennsylvania or the Episcopal Church staff upon the participant's arrival at the program.

ALLERGIES:

Please list all known allergies below.

MEDICATION TYPE	DESCRIBE REACTION TO EACH MEDICATION TYPE AND BEST MANAGEMENT OF THAT REACTION
_____	_____
_____	_____
_____	_____

FOOD TYPE	DESCRIBE REACTION TO EACH FOOD TYPE AND BEST MANAGEMENT OF THAT REACTION
_____	_____
_____	_____
_____	_____

OTHER ALLERGIES (Please include: Insect Stings, Hay Fever, Asthma, Animal Dander, etc.)	DESCRIBE REACTION TO EACH ALLERGY TYPE AND BEST MANAGEMENT OF THAT REACTION
_____	_____
_____	_____
_____	_____

MEDICATIONS:

Please list *all* medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep all medication its original container that easily identifies the prescribing physician (in the case of a prescription drug), the name of the medication, the dosage, and the frequency of administration.

The participant takes **NO** medications on a routine basis.

The participant currently takes the following medication on a routine basis.

MEDICATION # 1 _____ DOSAGE _____ SPECIFIC TIMES PER DAY _____

REASON _____

MEDICATION # 2 _____ DOSAGE _____ SPECIFIC TIMES PER DAY _____

REASON _____

MEDICATION # 3 _____ DOSAGE _____ SPECIFIC TIMES PER DAY _____

REASON _____

MEDICATION # 4 _____ DOSAGE _____ SPECIFIC TIMES PER DAY _____

REASON _____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer: _____

RESTRICTIONS

The following restrictions apply to this participant.

DIETARY

- DOES NOT EAT RED MEAT DOES NOT EAT PORK DOES NOT EAT EGGS
 DOES NOT EAT POULTRY DOES NOT EAT SEAFOOD DOES NOT EAT DAIRY PRODUCTS
 OTHER (Please describe further) _____

PARTICIPANT MEDICALLY EXEMPT FROM BELOW ACTIVITIES (Explain any restrictions to physical activity):

Are there limitations, adaptations, or restrictions that need to be placed on certain physical activities? Please describe in the space below.

GENERAL QUESTIONS:

Please describe all "YES" answers in the space provided below the following questions.

- | | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| All these questions are to be answered about the participant: | | | | | |
| 1) Had any recent injury, illness or infectious disease?..... | <input type="checkbox"/> | <input type="checkbox"/> | 9) Ever had frequent ear infections?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Have chronic or recurring illness/condition?..... | <input type="checkbox"/> | <input type="checkbox"/> | 10) Ever passed out during exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Ever been hospitalized?..... | <input type="checkbox"/> | <input type="checkbox"/> | 11) Ever been dizzy before or during exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Ever had surgery?..... | <input type="checkbox"/> | <input type="checkbox"/> | 12) Ever had seizures?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Have frequent headaches?..... | <input type="checkbox"/> | <input type="checkbox"/> | 13) Ever had chest pain during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Ever had a head injury?..... | <input type="checkbox"/> | <input type="checkbox"/> | 14) Ever had high blood pressure?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Ever been knocked unconscious?..... | <input type="checkbox"/> | <input type="checkbox"/> | 15) Ever had back problems?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Wear glasses, contacts or protective eyewear?..... | <input type="checkbox"/> | <input type="checkbox"/> | 16) Ever had back problems?..... | <input type="checkbox"/> | <input type="checkbox"/> |

21) Ever had problems with joints (knees)?..... **YES** **NO**

22) Bringing an orthodontic appliance?.....

23) Have any skin problems (rash, acne, itching)?.....

24) Have diabetes?.....

25) Have asthma?.....

26) Have mononucleosis in the past 12 months?.....

27) Had problems with diarrhea/constipation?.....

28) Have sleepwalking problems?.....

17) If female, have an abnormal menstrual history?..... **YES** **NO**

18) Have a history of bed-wetting?.....

19) Ever have an eating disorder?.....

20) Ever have emotional difficulties for which professional help was sought?.....

To describe further: _____

Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

TB Mantoux Test

Date of last test _____

Result:

- Positive
- Negative

Please give all dates of immunization for the following:

Vaccine:

- DTP
- TD (tetanus/diphtheria)
- Tetanus
- Polio
- MMR
- or Measles
- or Mumps
- or Rubella
- Haemophilus Influenza B
- Hepatitis B
- Varicella (Chicken Pox)

Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____

USE THIS SPACE TO PROVIDE ANY ADDITIONAL INFORMATION ABOUT THE PARTICIPANT'S BEHAVIOR AND PHYSICAL, EMOTIONAL, OR MENTAL HEALTH ABOUT WHICH THE EPISCOPAL DIOCESE OF PA OR THE EPISCOPAL CHURCH PERSONNEL SHOULD BE AWARE:

NAME OF FAMILY PHYSICIAN _____ PHONE _____

ADDRESS _____

NAME OF FAMILY DENTIST/ORTHODONIST _____ PHONE _____

ADDRESS _____

HEALTH CARE RECCOMENDATIONS BY LICENSED MEDICAL PERSONNEL:

I EXAMINED THIS INDIVIDUAL ON _____
 (Exam must have been within 12 months prior to trip attendance. A new exam is not necessarily required for trip attendance.)
 BP _____ WEIGHT _____ HEIGHT _____

IN MY OPINION, THE ABOVE APPLICANT IS IS NOT ABLE TO PARTICIPATE IN AN ACTIVE PROGRAM.
 THE APPLICANT IS UNDER THE CARE OF A PHYSICIAN FOR THE FOLLOWING CONDITIONS: _____

TREATMENT TO BE CONTINUED ON TRIP.

MEDICATIONS TO BE ADMINISTERED ON TRIP. (NAME, DOSAGE, FREQUENCY).

ANY MEDICALLY PRESCRIBED MEAL PLAN OR DIETARY RESTRICTIONS.

KNOWN ALLERGIES.

DESCRIPTION OF ANY LIMITATION OR RESTRICTION ON TRIP ACTIVITIES.

ADDITIONAL INFORMATION FOR EPISCOPAL DIOCESE OF PA or _____ CHURCH AUTHORIZED HEALTH CARE PROVIDER.

During The Last 6 Months: Have There Been Any Medical Illnesses, Issues, or Concerns?

Please Describe Further:

I understand and I voluntarily agree that the information that I have submitted in that application is true and complete to the best of my knowledge. I understand and voluntarily agree that the Diocese of Pennsylvania or the Episcopal Church Parish may contact the physician listed in this application to verify this information. I also agree that without this completed medical release form signed by a qualified doctor the participant will not be able to either use official Mission Trip transportation or attend the Mission Trip.

SIGNATURE OF PARTICIPANT, PARENT OR CUSTODIAL GUARDIAN IF UNDER 18

Date ____/____/____

FULL NAME PRINTED _____