2017 Counselor Medical Form & Release

[This form can double for an intern application if you are applying to do both]

Name of Applicant: _____

The following must be completed and signed

Camp Activity/ Medical/ Photo Information: I, the parent/guardian of the above named applicant ("the applicant"), authorize the physician selected by St. Christopher to secure and administer treatment, including hospitalization. I further authorize the Executive Director of St. Christopher, or his agent, to consent to any x-ray or treatment necessary. I give permission for myself to participate in all summer camp activities, except those noted on the Health History. Photographs and interviews will be taken during the camp session, and may be published and used to illustrate and promote St. Christopher/ Diocese of South Carolina. Additionally, names and addresses may be used in mailing lists.

Reasonable precaution is exercised to see that St. Christopher is a safe place. Even so it is possible that illnesses and accidents, some requiring medical treatment, may occur. I agree to hold the Diocese of South Carolina, St. Christopher Camp and Conference Center, Camp St. Christopher, and all summer camp staff, interns, counselors, and affiliates harmless in the event of an accident, illness, or injury. In the event that the applicant becomes ill or is injured, the Camp Medical staff will act in accordance with the camp physician's "standing medical orders," and the information provided on the Health History. If the Camp nurse or director feel that the situation warrants further medical treatment, the camper/counselor will be referred to a licensed physician or medical facility for further evaluation and treatment.

The providers of all medical services will be instructed to send all bills directly to the applicant or their parent or guardian. I understand and accept that I will be responsible for and billed directly for any medical treatment for this individual. St. Christopher carries a secondary insurance policy which may help cover the cost of such medical expenses for accidents and illnesses/injuries contracted and or incurred while working at/for St. Christopher. This secondary policy will provide coverage only if there is no other insurance in effect or may pay amounts in excess of the expenses covered by your primary policy. For additional information, contact: The St. Christopher Summer Camp Director, Justin Johnson, at 843-768-1337. Additionally if the injury is work related, the center's Worker's Compensation Insurance may be applied for.

Printed Name of Applicant _____ Signature _____ Date _____

If Applicant is under 18, this form must also be signed by a parent or guardian.

Printed name of Parent/Guardian:_____ Signature:_____ Date:_____

Emergency Contact Information

Name_____Relationship_____

_____

Address City State Zip

(_____)_____-_____ (_____) _____-_____ (_____)_____-_____

Home Phone Cell Phone Business Phone

If above person is not available in emergency, additional emergency contact is:

Name_____Relationship_____

_____

Address City State Zip

(_____)_____-_____ (_____) _____-_____ (_____)_____-_____

Home Phone Cell Phone Business Phone

Do you have health insurance through others (e.g. parents)? Yes / No In whose name is the policy? _____

Health Insurance Provider _____ Policy # _____

Group # _____

St. Christopher Summer Camp Counselor Health History 2017

A physical examination and physician's authorization is required to participate in summer camp. The physical must have been performed on or after April 1, 2016. Please use this form.

Name: _____ D.O.B.: _____ /_____/_____ SEX: M F

"I have examined this individual, and release them to participate in all camp activities without restrictions, except those noted in #8." Note: a MD, PA, or CNP may sign this form.

MD, PA, CNP- Name (Print)_____Title _____

Signature _____ Date _____/_____/_____

Address_____ Phone (_____) _____- _____

1. Allergies to Food or Medication (potential reactions and treatments):_____
_____
2. Dietary Restrictions: _____
_____
3. Date last Tetanus Booster: _____ Are other immunizations current? _____
4. Operations or Serious Illnesses (dates):
_____
_____
5. Chronic / Recurring Illnesses (i.e. eating disorders, ear/throat infections, asthma, headaches, diabetes, seizures):
_____
_____
6. Recent Illnesses (past 3 months): _____
_____

7. Share other medical or social information that could help the nurse:

Listing of all Medications & Rx Taken:	5.
1.	6.
2.	7.
3.	8.
4.	9.

The following medications may be administered to this intern, if needed, while at camp:

Acetaminophen (active ingredient in Tylenol)	per label instructions	Yes _____	No _____
Ibuprofen (active ingredient in Advil)	per label instructions	Yes _____	No _____
Diphenhydramine HCl (active indredient in Benadryl)	per label instructions	Yes _____	No _____
Calcium carbonate, antacids (active ingredient in Tums)	per label instructions	Yes _____	No _____
Guaifenesin (active ingredient in Robitussin)	per label instructions	Yes _____	No _____

8. Additional Comments/ Recommendations /Restrictions, (athletics, running, sleeping, swimming, dining, etc.):
_____
_____
_____
9. Name (s) and phone #'s of Primary Physician and other physicians currently providing treatment (if applicable):
_____
_____
_____