Antiochian Village 2017 Camper Medical Form for Summer Camp

201 Saint Ignatius Trail, Bolivar, PA 15923 Phone: 724-238-9565 Fax: 724-238-6415
Email: office@avcamp.org

***Form must be received at least one month prior to camping session—**
Please make a copy of this form to keep on file for your own reference.

For Camp Use Only
Cabin # _____

Camper Name _____ *Date of Birth*_____ *Session of Camp attending* ___

HEALTH CARE RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL

I examined this individual on _____. BP : _____ Weight: _____ Height: _____

The applicant is under the care of a physician for the following conditions: _____

_____

Medications to be administered at camp (name, dosage, frequency): _____

_____

Treatment to be continued at camp: _____

Any medically-prescribed meal plan or dietary restrictions: _____

Known allergies (including food):_____

Description of any limitation or restriction on camp activities: _____

Additional information for health care staff at the camp: _____

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.

Signature of Licensed Medical Personnel: _____

Printed Name: _____Date: _____ Phone: _____

Address: _____ Fax: _____ __

PARENT/GUARDIAN AUTHORIZATIONS, PERMISSIONS AND AGREEMENT

This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer over-the-counter medications, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. 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. I understand that my insurance coverage for my child will be used as primary coverage in the event medical intervention is needed. I further understand that I will be responsible for expenses not covered by my insurance.

I understand all reasonable safety precautions will be taken at all times by the Antiochian Village and its agents during camp. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold the Antiochian Orthodox Christian Archdiocese, the Antiochian Village, its leaders, employees, and/or volunteers liable for damages, losses, disease, or injuries incurred by the subject of this form.

I agree that my child will abide by all the rules and guidelines set forth by the Antiochian Village for the safety and good health of the campers at camp. I also agree that if my child has to return home due to discipline violations, it will be at my own expense.

I agree to indemnify and hold harmless, the Antiochian Orthodox Christian Archdiocese, the Antiochian Village, their leaders, employees, and/or volunteers from any expenses, loses , claims, or damages incurred as a result of the acts or omissions of the subject of this form. This completed form may be photocopied for trips out of camp.

I hereby agree to indemnify and hold harmless the Antiochian Village, the Antiochian Orthodox Christian Archdiocese, their clergy, officers, directors, employees, staff and volunteers from any and all expenses, claims, costs or attorney fees incurred as a result of claims, actions and/or suits brought by me, my child or on my behalf or on my child's behalf or by anyone else as a result of any accident of injury occurring to me or my child.

**If for religious reasons you cannot sign this, contact the camp office for a legal waiver which must be signed for attendance*

Signature of parent/guardian or adult camper/staff _____

Printed Name _____ Date _____

SCREENING RECORD *For camp use only*

Updates/additions to health history noted ☐ Yes ☐ No ☐ None required

Date screened _____ Time _____ Screened by _____

Meds Received _____

_____

Current health needs identified _____

A photocopy of the front and back of your health insurance card is required for your camper.

Please include the name(s) of your camper(s).

Please send this to us via one of the following methods:

1) US Mail: 201 St. Ignatius Trail
Bolivar, PA 15923

or

2) Scan and Email to admin@avcamp.org

or

3) Fax to 724 238 6415