Metropolis of Boston / St. Catherine
Church Vacation Church School 2018
119 Common St. Braintree, MA 02184
HEALTHFORM

The information on this form is not part of the acceptance process, but is gathered to assist us in identifying appropriate care. Health history must be filled out by parents/guardians of minors or by adults themselves. Update required annually.

Name: _____Birth date:_____Social Security #:_____

Home Address:_____Gender: ☐ Male ☐ Female

Insurance Information

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name: _____ Group #: _____

*****Photocopy of front and back of health insurance card must be attached to this form*****

Parent/Guardian Authorizations: This health history is correct and complete as far as I know. The person herein described has permission to engage in all activities except as noted. I hereby give permission to the Metropolis, its directors, youth advisors, and staff to provide routine health care, 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 insurance purposes. I give permission to the Metropolis, its directors, youth advisors, and staff 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 Church to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of the Church.

Signature of parent/guardian or adult participant: _____

Printed Name: _____ Date: _____

I also understand and agree to abide by any restrictions placed on my participation in activities.

Signature of minor or adult participant: _____ Date: _____

Health History

The parent/guardian, or adult participant must fill in the following information. The intent of this information is to provide the Directors and Advisors the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to the Metropolis upon participant's participation in the program. Provide complete information so that the Metropolis can be aware of your needs.

Allergies	**Describe reaction and management of the reaction**
Medication:	
Food:	
Other Allergies (include insect stings, hay fever, asthma, animal dander, etc.)	

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. If possible, the camper should take their medications prior to arriving to camp each day. If medications need to be dispersed by camp staff, then please bring enough for each day. Medications should be given to the camp staff directly. Children are not to hold and administer their own medication. Please keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person takes NO medication on a routine basis.

☐ This person takes medications as follows:

Medication	**Dosage**	**Specific times taken each day**	**Reasons for taking**

Attach additional pages for more medications.

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

_____

Dietary Restrictions

X		X		X	
	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 (describe)				

General Questions (Explain "yes" answers below.)

Has/does the participant:	Yes	No	Has/does the participant:	Yes	No
Had any recent injury, illness or infectious disease?			Have a chronic or recurring illness/condition?		
Ever had problems with joints (e.g. knees, ankles)?			Ever been hospitalized?		
Have an orthodontic appliance brought to camp?			Have any skin problems (e.g. itching, rash, acne)?		
Ever had surgery?			Have diabetes?		
Have frequent headaches?			Have asthma?		
Wear glasses, contacts or protective eye wear?			Had mononucleosis in the past 12 months?		
Ever had frequent ear infections?			Had problems with diarrhea/constipation?		
Ever passed out during or after exercise?			Have problems with sleepwalking?		
Ever been dizzy during or after exercise?			If female, have an abnormal menstrual history?		
Ever had seizures?			Have a history of bed-wetting?		
Ever had chest pain during or after exercise?			Ever had an eating disorder?		
Ever had high blood pressure?			Ever had emotional difficulties for which professional help was sought?		
Ever been diagnosed with a heart murmur?			Ever had back problems?		

Please explain any "yes" answers, referencing the question. _____

_____

Which of the following has the participant had?

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

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the Metropolis should be aware. _____

_____

_____

Name of family physician: _____Phone:_____

Address: _____

Name of family dentist/orthodontist: _____Phone: _____

Address: _____