



# HOLY TRINITY GREEK ORTHODOX CHURCH

Our Mission: "To proclaim and live the Orthodox Christian Faith in its fullness as faithful members of the Body of Christ."

Reverend Father John Touloumes, *Economos*  
Reverend Father Radu Bordeianu, *Assistant Priest*



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## HEALTH INFORMATION AND EMERGENCY MEDICAL TREATMENT AUTHORIZATION FORM

EVENT: \_\_\_\_\_ DATES: \_\_\_\_\_ through \_\_\_\_\_

*Health history must be filled out and signed by parents/guardians of minors.*

Name of child \_\_\_\_\_ Birth date: \_\_\_\_\_

Home Address: \_\_\_\_\_

Gender:  Male  Female Social Security #: \_\_\_\_\_

### **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 child named above has permission to engage in all event activities except as noted. I hereby give permission to the event leaders 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 event leaders to arrange necessary related transportation for my/our child. In the event I/we cannot be reached in an emergency, I hereby give permission to the physician selected by the retreat organizers to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied.

Signature of parent/guardian 1: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Emergency Contact 1: Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Signature of parent/guardian 2: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Emergency Contact 2: Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

## Health History

Please list ALL medications (*including over-the-counter or nonprescription drugs*) taken routinely. Bring enough medication to last the entire time at the retreat. 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.**

Explain any restrictions to activity (*e.g. what cannot be done, what adaptations or limitation are necessary*)

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**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 or behavioral 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. \_\_\_\_\_

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