HFH Summer Camps WAKONDA LANOWA

ACCREDITED

MEDICAL: Health History and Examination Form for Camp Staff Applicants

Pages 1 – 3 should be completed by Applicant or guardian, if a minor.
Submit with Examination Form to your physician for review.

Applicant Last Name: Saad **Applicant First Name:** Ahmed **MI:**

Date of Birth: 12/09/1997 Age: 20 Gender: ☑ Male ☐ Female

Address: Grinfel Street, Police Buildings, Building 4, Apt. 74, 7th Floor, Alexandria, Egypt.

First Preferred Telephone Number: +2 010 230 34581 Second Preferred Telephone Number:

Custodial Parent/Guardian Information (If under 18 years old) Full Name:

Preferred Telephone Number: Business Telephone Number:

Address: (If different from above)

EMERGENCY CONTACT:

Name: Nehad El-Behiry Relationship: Mother Phone: +2 01023766659

MEDICAL INSURANCE INFORMATION: → **Please include a copy of current Insurance Card (if applicable).** Is the participant covered by family medical/hospital insurance? ☐ Yes ☑ No Note(I will be covered by my sponsor once I arrive)

Name of Insured: Insurance Co.:

Group or Policy #: Carrier Phone Number:

APPLICANT (OR PARENT/GUARDIAN) AUTHORIZATIONS

(*if for religious reasons you cannot sign this form, contact the camp for a legal waiver, which must be signed for attendance.*)

This health history is correct and complete as far as I know, and the person herein described has permission to work or participate in all camp activities except as noted. I give permission to camp medical staff to provide the non-prescription medications as needed based on the options selected herein.

Permission to Provide Necessary Treatment or Emergency Care:

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or 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 director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Meningitis Vaccination Response

If I am or my child is going to work in a camp setting, I confirm that I have read, or have had explained to me, the enclosed information about meningitis vaccination. If I choose not to have myself or my child vaccinated, I confirm that I understand the risk of not receiving the vaccine.

If a minor, I also understand and agree to abide by the restrictions placed on my work, participation and camp activities.

Signature of Participant: **Printed:** Ahmed Abdelaal saad **Date:** 03/20/2018

Signature of Parent/Guardian (if minor): **Printed:** **Date:**

MEDICAL: Health History

RESTRICTIONS
Dietary:

- ☐ Does not eat red meat
- ☑ Does not eat pork
- ☐ Does not eat eggs
- ☐ Does not eat poultry
- ☐ Does not eat seafood
- ☐ Gluten Intolerance
- ☐ Does not eat dairy products
- ☐ Other: _____

Please explain: _____

Activity/Assignment Restrictions:

Based on the job description for the applicant's position, please clarify any camp or work activities from which the applicant should be exempted or limited for health reasons and explain any physical limitations: _____

GENERAL QUESTIONS

Please check "Y" for Yes or "N" for No to answer each question about medical history.

1. Had any recent injury, illness, or infectious diseases?	☐ Y ☑ N	11. Ever had seizures?	☐ Y ☑ N
2. Have a chronic or recurring illness/condition?	☐ Y ☑ N	12. Ever had high blood pressure?	☐ Y ☑ N
3. Ever been hospitalized?	☐ Y ☑ N	13. Ever been diagnosed with a heart murmur?	☐ Y ☑ N
4. Ever had surgery?	☐ Y ☑ N	14. Ever had back or joint problems?	☐ Y ☑ N
5. Have frequent headaches?	☐ Y ☑ N	15. Have any skin problems (e.g., itching rash, acne)?	☐ Y ☑ N
6. Ever had a head injury or been knocked unconscious?	☐ Y ☑ N	16. Have diabetes?	☐ Y ☑ N
7. Wear glasses, contacts, and protective eyewear?	☑ Y ☐ N	17. Have asthma?	☐ Y ☑ N
8. Ever had frequent ear infections?	☐ Y ☑ N	18. Had mononucleosis in the past 12 months?	☐ Y ☑ N
9. Ever passed out during or after exercise?	☐ Y ☑ N	19. Had problems with diarrhea/constipation?	☐ Y ☑ N
10. Ever had dizziness or chest pain during or after exercise?	☐ Y ☑ N	20. If female, have an abnormal menstrual history?	☐ Y ☐ N

Explain "Y" answers, noting corresponding number:

8) I wear glasses Because my eye vision is not the best however, I do Fine without it and ~~don't~~ Not medically necessary

ALLERGIES

Does the applicant have allergies? ☐ **Yes** ☑ **No** Fill in what the applicant is allergic to, reaction and authorized management

Medication allergies: _____

Food allergies: _____

Other – insect stings, hay fever, etc.: _____

Does the applicant require an Epi-pen: ☐ **Yes** ☑ **No** If **'Yes'** Epi-pen must be brought by applicant to camp.

MEDICAL: Health History

NON-PRESCRIPTION MEDICATION

Homes for the Homeless Summer Camps generally has the following non-prescription medications available at the camp infirmary. Please check 'Yes' or 'No' next to all non-prescription medications that may be dispensed to you/your child at camp. Participant will be given the recommended dosage, which corresponds to their age and/or weight as per label instructions.

Medication (or equivalent)	Symptoms Treated	Can be used	Comments
Tylenol	Headache, Aches, Cramps	☑ Yes ☐ No	
Ibuprofen	Headache, Aches, Cramps	☑ Yes ☐ No	
Cough Syrup	Cough	☑ Yes ☐ No	
Cough Drops	Cough	☑ Yes ☐ No	
Visine	Red, Irritated Eyes	☑ Yes ☐ No	
Antifungal Cream/Spray	Itchy, Burning Feet	☑ Yes ☐ No	
Pepto-Bismol	Upset Stomach	☑ Yes ☐ No	
Kaopectate	Antidiarrheal	☑ Yes ☐ No	
Maalox	Antacid	☑ Yes ☐ No	
Rolaids	Antacid	☑ Yes ☐ No	
Antihistamines	Allergy	☑ Yes ☐ No	
Anbesol	Toothache	☑ Yes ☐ No	
Triple Antibiotic Ointment	Abrasions/Cuts	☑ Yes ☐ No	
Bengay	Sore Muscles	☑ Yes ☐ No	
Chloraseptic Spray	Sore Throat	☑ Yes ☐ No	
Solarcaine	Sunburn	☑ Yes ☐ No	

Note: The camp infirmary **WILL NOT** provide you/your child with any treatment not check off as "Yes."

ROUTINE MEDICATION

Please list **ALL** medications (including over-the-counter/ non-prescription drugs) taken routinely. Please check one below.

☐ This person takes **NO** medication on a routine basis
☐ This person takes medication as follows:

Medication	Dosage	Frequency	Reason For Taking
1.			
2.			
3.			

IMMUNIZATIONS

Please confirm date (month and year) of last tetanus shot: Year: 1998 Month: _____

➔ A copy of participant's **completed immunization records** must be submitted or have doctor fill in page 4

HFH Summer Camps
WAKONDA LANOWA

MUST BE COMPLETED, SIGNED AND STAMPED BY DOCTOR/HEALTH CARE PROVIDER

MEDICAL: Physical Examination

Applicant's Last Name: Saad First Name: Ahmed

D.O.B: 12/09/1997 Age: 20 Gender: ☑ M ☐ F BP: 120/80 Weight: 90 Height: 170

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

non.

Any medically prescribed meal plan or dietary restrictions: non.

Known allergies: non.

Describe any limitation or restriction on camp activities: non.

RECOMMENDATIONS AND RESTRICTIONS AT CAMP

Please list **ALL** medications (including over-the-counter/ non-prescription drugs) taken routinely. Please check one below.

☑ This person takes **NO** medication on a routine basis
☐ This person takes medication as follows:

Medication	Dosage	Frequency	Reason For Taking
1.			
2.			
3.			

IMMUNIZATION (Attach copy of official immunization record as well)

Please give all dates in Month and Year of immunization for:

Vaccine	Date:	MM/YY	MM/YY	MM/YY	MM/YY	MM/YY	MM/YY
DTP		2000	2002	___	___	___	___
DT (Diphtheria/Tetanus)		98	98	___	___	___	___
Polio		2/98	4/98	6/98	___	___	___
Tetanus		___	___	___	___	___	___
Hepatitis B		2/1998	4/98	6/98			
Haemophilus Influenza B		___	___	___			
MMR		___	___				
Measles		1998	___		Mumps	1998	___
Rubella		1998	___				
Varicella (chicken pox)		2010	___				
Meningococcal (Meningitis)		2014	2016				
Human Papillomavirus (HPV)		—	—				
Hepatitis A (HEP A)		2014	2016				

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TB Mantoux Test: Date of test:_____ Result: ☐ Negative ☐ Positive

Additional Comments:_____

DISEASE HISTORY

Which of the following illnesses has the participant had?

☐ Measles ☑ Chicken Pox ☐ German measles ☐ Mumps ☐ Hepatitis ☐ Varicella Zoster

PHYSICIAN AUTHORIZATIONS

Name of Applicant's Physician: Hesham Shaheen. Phone: 01223526585.

Address: Alexandria, Egypt.

Name of Applicant's Dentist: Amr Abdelaaty. Phone: 0122181607

Address: Alexandria, Egypt.

Physician/Health Care Provider's Statement:

"I have examined Ahmed Abdelaal saad and discussed the applicant's health history with the
Print Applicant's Name

applicant or the applicant's parent/guardian. In my opinion the above applicant is able work and participate in an active camp program. I hereby give permission to Homes for the Homeless Summer Camps medical staff to provide the above mentioned non-prescribed and prescribed medications to this applicant as needed."

MANDATORY

Printed: Hesham Shaheen. **Signature of Physician/Provider:** Hesham Shaheen

Title: M,S **Date of Examination:** 20/3/2018

Medical Office/Physician stamp *REQUIRED* here

دكتور
هشام شاهين
أخصائي الأمراض الباطنية والسكر

For camp use only

Screening Record

Date screened:_____ Time:_____am / pm Screened by_____

Meds received_____

Updated/additions to health history noted: ☐Yes ☐ No ☐ None required

Current health needs identified:_____

Observational notes:_____