

Clemson University Youth Camp/Program Health History Form A

To Parent(s)/Guardian(s): Please follow the instructions below: Attach additional information if needed.

Participant Name: _____
Last First Middle Initial

Dates will attend camp/program: from _____ to _____
Month/Day/Year Month/Day/Year

Birth Date: _____ Sex: _____ Age on arrival at camp/program: _____
Month/Day/Year

Participants Home Address: _____
Street & Number City State Zip

Parent or Guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship: _____ Preferred Phone: (____) _____ (____) _____
 Email: _____

Home Address: _____
Street & Number City State Zip

Second parent/guardian or other emergency contact:

Name: _____ Relationship: _____ Preferred Phone: (____) _____ (____) _____
 Email: _____

Additional contact in event parents(s)/guardian(s) can not be reached:

Name: _____ Relationship: _____ Preferred Phone: (____) _____ (____) _____
 Email: _____

Allergies: No Know Allergies.

- This participant is Allergic to:
- To Foods (*list*) _____ Reaction: _____
 - To Medications (*list*) _____ Reaction: _____
 - To the environment (*Insect Stings, Hay Fever, etc. -list*) _____ Reaction: _____
 - Other (*list*) _____ Reaction: _____

Diet, Nutrition: This participant eats a regular diet. This participant eats a regular vegetarian diet. This participant is Lactose intolerant.
 This participant is gluten intolerant: Other, **please explain in space.**

Restrictions:

- I have reviewed the program and activities of the program and feel the participant can participate without restrictions.
 I have reviewed the program and activities of the program and feel the participant can participate with the following restrictions or adaptations:
(Please describe below)

Medical Insurance Information:

This participant is covered by (family medical/hospital) insurance: Yes No

Health Care Providers:

Name of participants primary doctor: _____ Phone: (____) _____

Name of dentist: _____ Phone: (____) _____

PARENT AUTHORIZATION & PERMISSION TO TREAT:

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed program activities, except as noted by me and the examining physician. I hereby give permission to the medical personnel selected by the program director to provide routine health care: to administer medications; 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/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the program director to secure and administer treatment, including hospitalization, for the person named above.

Parent/Guardian Signature _____ Date _____ Relationship to participant: _____

Participant Name: _____
Last First Middle Initial

Medication: This participant takes NO medications on a routine basis
 This participant takes medications as follows (attach additional pages if needed)

Medication & Dose given:	Dosage:	Times Taken each Day:	Reason for Taking:

Non-prescription medications may be stocked by the program and are used on an **as needed basis** to manage illness and injury. **Please list any non-prescription medications that the participant should not be given.**

Health History: Check "yes" or "no" for each statement. Explain, "yes" answers below.

Has/does the participant:

- | | | | |
|------------------------------------|--|---|--|
| 1. Ever been hospitalized? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Had fainting or dizziness? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illness? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Ever had back/joint problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had recent infections disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Passed out/had chest pain during exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had recent injury? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problem with falling asleep/sleepwalking? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Have diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Had mononucleosis during the past 12 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Had seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. If female, have problems with periods/menstruation? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Have history of bedwetting? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Had asthma/wheezing/shortness of breath? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Have any skin problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Travel outside the country in the past 9 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain "yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Immunization History: Provide the month and year for each immunization. Copies of immunizations forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis (DTap) or (DdaP)						
Tetanus booster (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)						
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) test	Date:	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive			

Signature of Custodial Parent/Guardian _____ Date: _____ Relationship to Participant: _____

Mental, Emotional, and Social Health: Check "yes" or "no" for each statement.

Has the participant:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? Yes No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? Yes No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? Yes No
4. Had a significant life event that continues to affect the participant's life? Yes No

(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp/program may contact you for additional information.