Clemson University Youth Camp/Program Health Examination Form

THE FIRST PAGE AND TOP OF SECOND PAGE TO BE COMPLETED BY PARENT OR GUARDIAN. FOR MUST BE SIGNED AND DATED. (SEE PARENT'S AUTHORIZATION & PERMISSION TO TREAT)

Participant Name____
Last First Middle Initial
Birth Date _____________Sex ______Age _____ Social Security #_____________
Parent or Guardian (or Spouse)____
Phone: Day (____)________________ Evening (____)______________
Cell (____) ________________
Home Address____
Street & Number City State Zip
If not available in an emergency, notify:
1. Name_____________________________ Relationship to Camper___________

Home Phone Work Phone Cell Phone

2. Name_____________________________ Relationship to Camper___________

Home Phone Work Phone Cell Phone

HEALTH HISTORY: (Check if the participant has had any of the following – giving approximate dates where applicable.)

ALLERGIES:

Ear Infections ____________ Chicken Pox ___________ Hay Fever __________
Asthma ____________ Rheumatic Fever ___________ Ivy Poisoning ect. __________
Seizures ____________ Chest Pain passing out with exertion ___________ Insect Stings __________
Diabetes ____________ Penicillin __________
Behavior ____________ Other Drugs __________

Details of Above (frequency, severity, triggers) and include any additional medication or food allergies. ____
____
____
____
Operations or Serious Injuries (Dates)____________________________________
Chronic or Recurring Illness____
SUGGESTIONS FROM PARENTS: ____________________________________
____

IMMUNIZATION RECORD…CAMPERS CANNOT BE ACCEPTED WITHOUT THIS INFORMATION
Required immunizations must determined locally. This is a record of dates of basic immunizations and most recent booster doses.
DTP Series _________ booster _________ Tetanus booster (**within the last 10 years**) _________
Polio IPV _________ booster _________ MMR ______________________
Hepatitis B ___________________ Varicelle (chicken pox)__________________
Other state or municipal examinations required if any)______________________

MEDICATIONS BE TAKEN – to be completed and signed by a parent or legal guardian

____ This person takes NO medications on a routine basis.
____ This person takes medications as follows (attach additional pages if needed):

Medication:	Dosage:	Times taken each day:	Reason for taking:

THIS MUST BE SIGNED FOR CHILD TO ATTEND CAMP

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 camp activities, except as noted by me and the examining physician. I hereby give permission to the medical personnel selected by the camp 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 camp director to secure and administer treatment, including hospitalization, for the person named above.

Parent/Guardian Signature____ **Date**_______________________

MEDICAL EXAMINATION to be completed and signed by licensed medical personnel

Hgt_____________________ Wt_____________________ B.P._____________________
The applicant is under the care of a physician for the following conditions:
____
(For Girls and Women) Has this person menstruated?____________ If so, is her menstral history normal?_________
Special considerations____
Recommendations and restrictions while in camp____
Known allergies____
Special meal plans or diet restrictions____
Medications to be administered at camp (name, dosage, frequency if different from above)__________
____
Limitations or restriction on camp activities____
____
Additional information for camp health care personnel____
____

I examined this individual on _______________(date). In my opinion, the applicant is able to participate in an active camp program>

SIGNATURE OF LICENSED MEDICAL PERSONNEL____

Print Name_____________________________ **Title**_______________________________

Address________________________________ **Telephone**__________________________

____ **Date**________________________________