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 camper eats a regular diet. ☐ This camper eats a regular vegetarian diet. ☐ This camper is Lactose intolerant.
☐ This camper is gluten intolerant: ☐ Other, **please explain in space.**

Restrictions:

☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

☐ I have reviewed the program and activities of the camp and feel the camper 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 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___________________ Relationship to participant: ______________

Participant Name: ____
Last *First* *Middle Initial*

Medication:
☐ This camper takes NO medications on a routine basis
☐ This camper 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 camp/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 camper:

1. Ever been hospitalized? □ Yes □ No
2. Ever had surgery? □ Yes □ No
3. Have recurrent/chronic illness? □ Yes □ No
4. Had recent infections disease? □ Yes □ No
5. Had recent injury? □ Yes □ No
6. Have diabetes? □ Yes □ No
7. Had seizures? □ Yes □ No
8. Had headaches? □ Yes □ No
9. Have history of bedwetting? □ Yes □ No
10. Have any skin problems? □ Yes □ No
11. Wear glasses, contacts, or protective eyewear? □ Yes □ No
12. Had fainting or dizziness? □ Yes □ No
13. Ever had back/joint problems? □ Yes □ No
14. Passed out/had chest pain during exercise? □ Yes □ No
15. Have problem with falling asleep/sleepwalking? □ Yes □ No
16. Had mononucleosis during the past 12 months? □ Yes □ No
17. If female, have problems with periods/menstruation? □ Yes □ No
18. Have problems with diarrhea/constipation? □ Yes □ No
19. Had asthma/wheezing/shortness of breath? □ Yes □ No
20. Travel outside the country in the past 9 months? □ Yes □ 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: ☐ Participant has been fully immunized with all up to date immunizations required for school.
☐ Participant has not been fully immunized.

Signature of Custodial Parent/Guardian: ______________________ Date: ____________ Relationship to Participant ______________

Tetanus or Tetanus Booster (dT) or (TdaP) Most Recent Dose ____________
Month/Year

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.

Camper Health-Care Recommendations
by Licensed Medical Personnel Form B

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*

MEDICAL EXAMINATION to be completed and signed by licensed medical personnel

Physical Exam done today: Yes No (If "No," date of last physical: ______________)
Month/Day/Year

Hgt____________________ Wt____________________ B.P.____________________

PcPO standards specify physical exam within last 24 months.

Allergies: ☐ No Known Allergies
☐ Known allergies ***(list)*** ____

Diet, Nutrition: ☐ Eats a regular diet.
☐ Special meal plans or diet restrictions ***(describe below)*** ______________________________

____

____

The participant is under the care of a physician for the following conditions: (describe below) ☐ None

____

____

____

Medication: ☐ No daily Medications.
☐ Will take the following medication(s) while at camp/program: ***(name, dosage, frequency – describe below)***

Other treatments/therapies to be continued at camp/program: (describe below) ☐ None needed

Do you feel the participant will require limitations or restrictions while in camp/program? ☐ Yes ☐ No

If you answered "yes" to the question above, what do you recommend? (describe below – attach additional information if needed)

I examined this individual on ________________. In my opinion, the applicant is able to participate in an active camp program.
Month/day/year

SIGNATURE OF LICENSED MEDICAL PERSONNEL______________________________ Date: ________________
Month/Day/Year

Print Name______________________________ Title______________________________

Address____ Phone: (______) ________________
Street & Number *City* *State* *Zip*