# 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: |
|---|---|---|---|
| | | | |
| | | | |
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| | | | |

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*