Clemson University 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:_____
  _____ Reaction:_____
- ☐ To Medications ***(list)*** _____ Reaction: _____
  _____ Reaction:_____
- ☐ To the environment ***(Insect Stings, Hay Fever, etc. -list)*** _____
  Reaction: _____
  _____ Reaction:_____
- ☐ Other ***(list)*** _____Reaction: _____
  _____ 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)**

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? □ 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: 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
Diptheria, 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:		☐Negative	☐Positive		

If your participant has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being fully immunized.

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

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

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.

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: (_____)_____

Participant 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*

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