

CAMP HEALTH EXAMINATION FORM

Clemson University Outdoor Lab

Clemson, SC 29634-0737

(864) 646-7502 phone; (864) 646-3620 fax

**THIS SIDE AND TOP OF SECOND PAGE TO BE COMPLETED BY PARENT OR GUARDIAN.
FORM MUST BE SIGNED AND DATED (SEE PARENT'S AUTHORIZATION & PERMISSION TO TREAT)**

Check camp attending:

Jaycee Camp Hope Camp Sertoma Camp Odyssey Camp Sunshine Camp Lions Den

Name _____
Last First 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. _____ Relationship to camper _____
Name

Home Phone Work Phone Cell Phone

2. _____ Relationship to camper _____
Name

Home Phone Work Phone Cell Phone

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

Ear Infections _____	Behavior _____	ALLERGIES:
Asthma _____	Rheumatic Fever _____	Food _____
Seizures _____	Chest Pain/passing _____	Drugs _____
Diabetes _____	out with exertion _____	Insect Stings _____
		Penicillin _____

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 be 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 _____ Varicella (chicken pox) _____

Other state or municipal examinations required (if any) _____

MEDICATIONS BEING TAKEN

- This person takes NO medications on a routine basis
- This person takes medications as follows (**any medications listed MUST be brought to camp in original prescription container**):

Medicine:	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 menstrual history normal? _____

Recommendations and restrictions while in camp.

Treatment to be continued at camp _____

Known allergies _____

Special meal plans or diet restrictions _____

Medications to be administered at camp (name, dosage, frequency if different from above) _____

Limitation or restriction on camp activities _____

Additional information for camp health care personnel _____

Special considerations: _____

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 _____
 (M.D. or Physicians Assistant operating under auspices of M.D.)

Print Name _____

Title _____

Address _____

Telephone _____

Date _____

CAMPER NAME

SOC. SECURITY #