CAMP HEALTH EXAMINATION FORM

Clemson University Outdoor Laboratory
Lehotsky Hall, Box 340735, Clemson, SC 29634-0735
(864) 646-7502 phone; (864) 646-3620 fax

Session number or session dates _____

THIS SIDE TO BE COMPLETED BY PARENT OR GUARDIAN WITHIN SIX MONTHS OF CAMP. FORM MUST BE SIGNED AND DATED (SEE PARENT'S AUTHORIZATION BELOW)

Name _____
Last First Initial

Birth Date _____ Sex _____ Age _____

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)

				ALLERGIES:	
Ear Infections	_____	Chicken Pox	_____	Hay Fever	_____
Asthma	_____	Rheumatic Fever	_____	Ivy Poisoning, etc.	_____
Seizures	_____	Chest Pain/passing		Insect Stings	_____
Diabetes	_____	out with exertion	_____	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: _____

_____

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** _____

THIS MUST BE SIGNED FOR CHILD TO ATTEND CAMP

MEDICATIONS BEING TAKEN

☐ This person takes NO medications on a routine basis

☐ This person takes medications as follows:

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

(attach additional pages if needed)

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_____

Polio IPV _____booster_____

Hepatitis B _____ _____ _____

Tetanus booster **(within the last 10 years)** _____

MMR _____

Varicella (chicken pox) _____

Other state or municipal examinations required (if any) _____

MEDICAL EXAMINATION to be completed and signed by PHYSICIAN OR PHYSICIAN'S ASSISTANT.

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? _____

Special considerations: _____

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 _____

_____

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

SIGNATURE OF PHYSICIAN OR PHYSICIAN'S ASSISTANT_____

_____ _____

Print Name Title

Address _____ Telephone _____

_____ Date _____