2016 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)

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

- OVER -

☐ 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 ___/____/2016

CAMPER NAME

SOC. SECURITY #

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 _____/____/2016