CLEMSON® UNIVERSITY LEARNING INSTITUTE

PARTICIPANT HEALTH FORM

(One form to be completed by each participant)

☐ Male ☐ Female

Participant Name | *Date of Birth* | *Participant Sex*

IMPORTANT: Please notify the director if the participant is exposed to any communicable diseases during the two (2) weeks prior to arrival.

ALLERGIES & MEDICATIONS

☐ YES ☐ NO Is the participant allergic to medications?

☐ YES ☐ NO Does the participant take medication, including over-the-counter, on a routine basis?

☐ YES ☐ NO Is the participant allergic to the environment? *(e.g. insect stings, hay fever, etc.)*

☐ YES ☐ NO Is the participant allergic to foods or have any dietary restrictions?

☐ YES ☐ NO Other allergies not listed *(e.g. latex, bleach, etc.)*

(If yes, list & describe reaction. Attach additional pages if necessary)

HEALTH HISTORY *(Check all that apply.)*

- ☐ Asthma/Shortness of Breath
- ☐ Back/Joint Problems
- ☐ Bed Wetting
- ☐ Chest Pain
- ☐ Diarrhea
- ☐ Diabetes
- ☐ Fainting or Dizziness
- ☐ Females: Menstrual Issues
- ☐ Glasses or Contacts
- ☐ Headaches
- ☐ Hospitalized
- ☐ Problem Falling Asleep
- ☐ Recent Infectious Disease
- ☐ Recent Injury
- ☐ Recurrent/Chronic Illness
- ☐ Seizures
- ☐ Skin Problems
- ☐ Surgery
- ☐ Past 9 months: Left Country
- ☐ Past 12 months: Mononucleosis
- ☐ Other
- ☐ None of these apply

Explain each checked item. Attach additional pages if necessary.

MENTAL, EMOTIONAL, AND SOCIAL HEALTH

- ☐ Been treated for attention deficit disorder (ADD) or attention deficit/ hyperactivity disorder (ADHD)?
- ☐ Seen a professional to address mental, emotional, or behavioral health concerns or an eating disorder?
- ☐ Experienced significant homesickness?
- ☐ Had a significant life event? (Death of a loved one, family change, adoption, foster care, new sibling, etc.)
- ☐ None of these apply

Explain each checked item:

TETANUS BOOSTER

Date of Last Tetanus/Tetanus Booster Dose

MM/YYYY or Date Unknown

☐ None received due to religious or other reasons

IMMUNIZATIONS *18 years and younger*

☐ Participant has been fully immunized with all up to date immunizations required for school.

☐ Participant **has not** been fully immunized. (due to religious or other reasons)

RESTRICTIONS List activities the participant **MAY NOT** participate in.

☐ Participant has **NO** restrictions

OVER-THE-COUNTER (OTC) MEDICATION CONSENT

I consent for the camp/program to dispense the OTC medication as indicated below. OTC medications will not be dispensed without the consent of the parent, no exceptions. Medications are dispensed under the guidance of the camp medical officer. If my child cannot remain at camp due to health reasons, I understand I will not receive a refund of camp fees. *(Check all that apply.)*

- ☐ Acetaminophen
- ☐ Antibiotic Ointment
- ☐ Benadryl
- ☐ Calamine Lotion
- ☐ Hydrocortisone Cream
- ☐ Ibuprofen
- ☐ Imodium AD
- ☐ Pepto Bismol
- ☐ Robitussin DM
- ☐ Tums
- ☐ I do not consent to any OTC medications

HEALTH CARE PROVIDERS

☐ Participant has family health insurance.

☐ Participant **DOES NOT** have family health insurance.

Primary Care Physician Name | Phone Number

Dentist Name | Phone Number

INSURANCE Limited medical insurance provided for every participant.

Program insurance coverage is in effect while the participant is in attendance and while en route to and from the program. If the participant returns home sick or injured without seeing a doctor while in attendance, the participant must see a doctor within 24 hours for insurance to pay. Medical costs that exceed the policy amounts will be the responsibility of the participant.

PARTICIPANT AUTHORIZATION & PERMISSION TO TREAT

As the parent or legal guardian of the minor child named above, I understand that the information requested on this form is intended to help inform program staff of any pre-existing medical conditions. If participant has any a pre-existing medical condition, participation in any strenuous activities or recreational time may not be recommended. This information will be kept in strict confidence and will only be shared with your permission. The university requests the information so that, in case of emergency, we will have accurate information to provide and/or seek appropriate treatment for participant. You are accountable for providing an accurate medical history. Final determination about whether to participate is the responsibility of you and your physician. **This health history is correct so far as I know, and the participant has permission to engage in all prescribed 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 participant. 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 participant.**

Participant Signature (18 or older) | Date

☐ *By checking this box, you acknowledge your electronic signature is the legal equivalent of your manual signature on this form.*

Parent/Guardian Signature | Date | Relationship to Participant

☐ *By checking this box, you acknowledge your electronic signature is the legal equivalent of your manual signature on this form.*