STAFF HEALTH FORM

CLEMSON® UNIVERSITY LEARNING INSTITUTE

Staff Name: _____

Date of Birth: _____

HEALTH HISTORY Please list any health conditions that may affect your ability to perform the functions of your position:

_____

_____

ALLERGIES Please list any allergies (foods, medicines, insect stings, hay fever, etc.): _____

_____

MEDICATIONS Please list any medications that you take on a routine basis (attach additional pages if necessary): _____

_____

DATE OF LAST TETANUS/TETANUS BOOSTER: _____
MM/YYYY

PERMISSION TO TREAT:

This health history is correct so far as I know, and I am able 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. I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization.

Staff Signature: _____ Date: _____

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

MEDICAL STATEMENT (to be completed by "licensed medical personnel")

Dear Licensed Medical Personnel:

We, Clemson University Learning Institute, require that a participant attending a program be examined by licensed medical personnel within 24 months prior to the date of program activity (such activities may include horseback riding, swimming, other water activities, challenge courses, and other outdoor activities). Your support in helping this participant is very much appreciated.

I examined _____ on _____ and it is my
Participant Name Date of Examination

opinion that he/she is physically able to engage in activities, except as follows: _____

_____ and with these precautions:

_____.

Physician Name _____ **Office Phone** _____

Signature _____ **Date** _____ **Hospital Phone** _____

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

Address _____

_____

"Licensed Medical Personnel" includes those licensed physicians, certified or certification-eligible nurse practitioners, or other medical personnel who are certified by the state to conduct health examinations. Form-SHF-24