Clemson University Youth Camp/Program Health History

To Parent(s)/Guardian(s): Please follow the instructions below: Attach additional information if needed.

Participant Name: _____
Last *First* *Middle Initial*

Dates will attend camp/program: from _____ to _____
Month/Day/Year *Month/Day/Year*

Birth Date: _____ Sex: _____ Age on arrival at camp/program: _____
Month/Day/Year

Participants Home Address: _____
Street & Number *City* *State* *Zip*

Parent or Guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship: _____ Preferred Phone:(____)_____ (____)_____
Email: _____

Home Address: _____
Street & Number *City* *State* *Zip*

Second parent/guardian or other emergency contact:

Name: _____ Relationship: _____ Preferred Phone:(____)_____ (____)_____
Email: _____

Additional contact in event parents(s)/guardian(s) can not be reached:

Name: _____ Relationship: _____ Preferred Phone:(____)_____ (____)_____
Email: _____

Allergies: ☐ No Know Allergies.

☐ This participant is Allergic to:
- ☐ To Foods ***(list)*** _____ Reaction: _____
- ☐ To Medications ***(list)*** _____ Reaction: _____
- ☐ To the environment ***(Insect Stings, Hay Fever, etc. -list)*** _____ Reaction: _____
- ☐ Other ***(list)*** _____ Reaction: _____

Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet. ☐ This camper is Lactose intolerant. ☐ This camper is gluten intolerant: ☐ Other, **please explain in space.**

Restrictions:
☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations:
(Please describe below)

Medical Insurance Information:
This participant is covered by (family medical/hospital) insurance: ☐ Yes ☐ No

Health Care Providers:
Name of participants primary doctor: _____ Phone: (____)_____

Name of dentist: _____ Phone: (____)_____

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**_____ **Relationship to participant:** _____

Participant Name: _____
Last *First* *Middle Initial*

Medication: ☐ This camper takes NO medications on a routine basis
☐ This camper takes medications as follows (attach additional pages if needed)

Medication & Dose given:	Dosage:	Times taken each day:	Reason for taking:

Non-prescription medications may be stocked by the camp/program and are used on an ***as needed basis*** to manage illness and injury. **Please list any non-prescription medications that the participant should *not* be given.**

Health History: Check "yes" or "no" for each statement. Explain, "yes" answers below.
Has/does the camper:

1. Ever been hospitalized? □ Yes □ No
2. Ever had surgery? □ Yes □ No
3. Have recurrent/chronic illness? □ Yes □ No
4. Had recent infections disease? □ Yes □ No
5. Had recent injury? □ Yes □ No
6. Have diabetes? □ Yes □ No
7. Had seizures? □ Yes □ No
8. Had headaches? □ Yes □ No
9. Have history of bedwetting? □ Yes □ No
10. Have any skin problems? □ Yes □ No
11. Wear glasses, contacts, or protective eyewear? □ Yes □ No
12. Had fainting or dizziness? □ Yes □ No
13. Ever had back/joint problems? □ Yes □ No
14. Passed out/had chest pain during exercise? □ Yes □ No
15. Have problem with falling asleep/sleepwalking? □ Yes □ No
16. Had mononucleosis during the past 12 months? □ Yes □ No
17. If female, have problems with periods/menstruation? □ Yes □ No
18. Have problems with diarrhea/constipation? □ Yes □ No
19. Had asthma/wheezing/shortness of breath? □ Yes □ No
20. Travel outside the country in the past 9 months? □ Yes □ No

Please explain "yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

_____
_____
_____
_____
_____

Immunization History: ☐ Participant has been fully immunized with all up to date immunizations required for school.
☐ Participant has not been fully immunized.

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Participant _____

Tetanus or Tetanus Booster (dT) or (TdaP) Most Recent Dose _____
Month/Year

Mental, Emotional, and Social Health: Check "yes" or "no" for each statement.
Has the participant:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐Yes ☐No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐No
4. Had a significant life event that continues to affect the participant's life? ☐ Yes ☐No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp/program may contact you for additional information.

Clemson University Parental Permission Form and Release of Liability for Youth Camps or Programs

I, _____, am the parent and/or legal guardian of _____, a minor child under the age of 18 years. I would like to have my child participate in the Spirit Squad Youth Clinic at Clemson University will take place on Saturday, September 2, 2017.

In consideration for my child being allowed to participate in the Spirit Squad Clinic, I the undersigned, acknowledge, appreciate and agree that:

1. This Spirit Squad Clinic affords my child the opportunity to participate in activities, including, but not limited to: dancing, walking, jumping, stretching, and cheering. There are inherent risks involved with these activities, including but not limited to exhaustion, tripping/falling, and leg/arm soreness. I choose to voluntarily allow my child to participate in the Spirit Squad Clinic. I voluntarily assume full responsibility for any risk of loss, property damage or personal injury, including death, which may be sustained by my child as a result of his/her participation.

2. I certify that I have adequate health insurance necessary to provide for and pay for any medical costs that may directly or indirectly result from my child's participation in the Spirit Squad Clinic. I agree to pay for any medical costs that exceed the limits of my insurance coverage.

3. I hereby release, waive, and discharge Clemson University and its Board of Trustees, its officers, agents, employees and representatives from all claims, demands, liabilities, rights and causes of action of whatever kind or nature, that may result from or occur during my child's participation in the Spirit Squad Clinic, whether caused by negligence of the Clemson University, its Board of Trustees, officers, agents, employees or representatives or otherwise. I also agree to indemnify and hold harmless Clemson University for any loss, liability, damage or costs, including court costs and attorney's fees that may occur as a result of my or my child's negligent or intentional act or omission while participating in the Spirit Squad Clinic.

I HAVE CAREFULLY READ THIS PERMISSION AND RELEASE OF LIABILITY AND HAVE HAD SUFFICIENT TIME TO SEEK EXPLANATION OF THE PROVISIONS CONTAINED ABOVE. AFTER CAREFUL CONSIDERATION, I SIGN THIS DOCUMENT VOLUNTARILY AND WITHOUT ANY INDUCEMENT.

_____ _____

Signature of Parent and/or Legal Guardian Date