SHS 0528

Illinois State University
HEALTH HISTORY / PARENTAL CONSENT
CAMP PARTICIPANT

FOR CAMP USE
_____ **Allergies**
_____ **Routine meds**

Please complete this form and return to the sponsor of the camp. This form must be completed for each participant and presented to the Student Health Service *by the sponsoring camp* before he/she will be treated. Please use black ink and press firmly.

Name_____ Age_____ Gender ☐ F ☐ M
Last First MI

Address_____
Street / Number City State Zip

Birthdate____/____/____ Camp Attending_____ Dates_____

EMERGENCY CONTACTS

Parent / Guardian_____
Last First Relationship

Home Address_____ Phone_____

Work Address_____ Phone_____

Second Parent/Guardian_____
Last First Relationship

Home Address_____ Phone_____

Work Address_____ Phone_____

If above not available, in an emergency contact:

Name_____
Last First Relationship

Home Address_____ Phone(____)_____

Work Address_____ Phone(____)_____

DISEASE HISTORY: ☐ Convulsions ☐ Heart defect/murmur ☐ Asthma ☐ Chicken Pox
☐ Diabetes ☐ Bleeding disorder ☐ Surgery (past 2 years) ☐ Measles ☐ Mumps

Brief description and dates of items checked_____

Last Tetanus / Diptheria immunization **Date**____/____/____

Current Medications - type, dose, and frequency (list)_____

Allergies - include allergies to medications, foods, sting, other substances (list)_____

FOR FEMALES: Has this person menstruated? ☐ Yes ☐ No If no, does she know about menstruation?
If yes, are "periods" normal? ☐ Yes ☐ No (i.e., flow, cramping)

INSURANCE CARRIER_____ Policy / Group Number_____

AUTHORIZATION FOR TREATMENT: I hereby give my permission to the physicians/clinicians selected by the camp sponsors to order x-rays, lab tests, and provide treatment for my child as named above while attending the camp named above. In the event I cannot be reached for an emergency, I hereby give permission to the physicians/clinicians selected by the camp sponsors to secure and administer such treatment(s) as may be necessary, including hospitalization for my child as named above while attending the camp named above. I also authorize Illinois State University Student Health Service to release copies of my child's medical record to hospitals and other physicians/clinicians to which they are referred and to insurance companies for payment of the medical claim. A photocopy of this authorization is as valid as the original.

_____
Signature of Parent / Guardian (required for participation) Date

Address_____
Street / Number

_____
City State Zip

Name_____
Address_____
Phone_____
Date of Birth_____

Camper's Name Last First MI

Camp Address