Florida Atlantic University Pre-collegiate Program Health Examination Form

(*Insert Camp/Program name and address here*)

THE FIRST PAGE 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)

Participant Name_____

Birth Date _____ Sex _____ Age _____

Parent or Guardian (or Spouse)_____

Phone: Day (_____)_____ Evening (_____)_____ Cell (_____)

Home Address_____

Street & Number City State Zip

If not available in an emergency, notify:

1. Name_____ Relationship to Par_____

   Home Phone ( )_____ Work Phone ( )_____ Cell Phone ( )_____

2. Name_____ Relationship to Camper_____

   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 _____ Chicken Pox _____ Hay Fever _____

Asthma _____ Rheumatic Fever _____ Ivy Poisoning etc. _____

Seizures _____ Chest Pain _____ Diabetes _____

Passing out upon exertion _____

Allergies:

Penicillin _____ Insect Stings _____ Food _____

(Please provide specific details below.)

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 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 _____ Varicelle (chicken pox)_____

Other state or municipal examinations required if any)_____

MEDICATIONS THAT MUST BE TAKEN – to be completed and signed by a parent or legal guardian

____ This person takes NO medications on a routine basis.

____ This person takes medications as follows (attach additional pages if needed):

Medication:	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 seek and authorize necessary medical care in the event of an emergency. In the event that I cannot be reached in an emergency, I hereby give permission to the physician to provide treatment, including hospitalization, for the person named above.

Parent/Guardian Signature_____
Date_____

MEDICAL EXAMINATION to be completed and signed by licensed medical personnel

Hgt: _____ Wgt: _____ 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 menstral history normal?_____

Special considerations_____
_____

Recommendations and restrictions while in camp_____

Known allergies_____
_____

Special meal plans or diet restrictions_____

Medications to be administered at camp (name, dosage, frequency if different from above)_____

_____
_____

Limitations or restriction on camp activities_____

_____
_____

Additional information for camp health care personnel_____

_____
_____

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_____

Print Name_____

Title_____

Address_____

Telephone_____

Date_____