

**Clemson University Youth Camp/Program Health Examination Form
Clemson Women's Soccer Academy**

**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 _____
Last First Middle Initial

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 Camper _____

Home # _____ Work # _____ Cell# _____

INSURANCE INFORMATION: (MUST HAVE INSURANCE TO PARTICIPATE)

Company Name: _____ Policy #: _____

HEALTH HISTORY: (Check if the participant has had any of the following – giving approximate dates where applicable.)

Ear Infections _____	Chicken Pox _____	ALLERGIES:
Asthma _____	Rheumatic Fever _____	Hay Fever _____
Seizures _____	Chest Pain passing _____	Ivy Poisoning ect. _____
Diabetes _____	out with exertion _____	Insect Stings _____
Behavior _____		Penicillin _____
		Other Drugs _____

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...CAMPER'S CANNOT BE ACCEPTED WITHOUT THIS INFORMATION

Required immunizations must be 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 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 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 _____

MEDICAL EXAMINATION to be completed and signed by licensed medical personnel:

Hgt _____ Wt _____ 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 menstrual 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 soccer camp program.

SIGNATURE OF LICENSED MEDICAL PERSONNEL _____

Print Name _____ **Title** _____

Address _____

Telephone _____ **Date** _____