

Health History & Examination Form - South Carolina Envirothon Program

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The information on this form is not part of any acceptance process for students or staff, but is gathered to assist us in identifying appropriate care. This form, except for the "Health Recommendations of Licensed Medical Personnel", is to be filled in completely by parents/guardians of minors or by adults themselves.

Name: _____ Date of Birth: _____

Home Address: _____

Student Gender: Male _____ Female _____

Custodial Parent/Guardian: _____ Telephone: _____

Home Address (if different from above): _____

Business Phone: _____ Cell Phone: _____ Home Phone: _____

We should try contacting you first at the _____ Business _____ Cell _____ Home

Second Parent or Guardian Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

Business Address: _____ Phone: _____

If neither of above is available, in an emergency notify:

Name: _____ Phone: _____

Relationship: _____ Cell Phone: _____

Address: _____

INSURANCE INFORMATION:

Is the participant covered by family medical/hospital insurance? Yes _____ No _____

If so, indicate carrier or plan name: _____ -Group # _____

Carrier's Address: _____

Name of insured: _____ Relationship to participant: _____

Policy number or insurance ID number: _____

*Permission to Provide Necessary Treatment or Emergency Care:

I hereby give permission to the medical personnel selected by camp or program director 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/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by SCDNR or its representatives to secure and administer treatment including hospitalization for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult staffer: _____ Print Name: _____

Witness: _____ Print Name: _____ Date: _____

HEALTH HISTORY

The parent/guardian, or adult staff member must fill in the following information. The intent of this information is to provide camp or program health care personnel the background to provide adequate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp or program health care personnel upon participant's arrival on site. Provide complete information so that the camp can be aware of your needs.

Food Allergies: (List)

Other Allergies: (Describe reaction and management of reaction)

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time of camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, dosage, and frequency of administration.

_____ This person takes NO medications on a routine basis. (Initial if applicable)

This person takes medications as follows:

Med #1 _____ Dosage: _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage: _____ Specific times taken each day _____

Reason for taking _____

Med #3 _____ Dosage: _____ Specific times taken each day _____

Reason for taking _____

RESTRICTIONS

The following restrictions apply to this individual:

Dietary: Does not eat red meat _____ Does not eat pork _____ Does not eat eggs _____

Does not eat poultry _____ Does not eat seafood _____ Does not eat dairy products _____

Other (describe) _____

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary):

GENERAL QUESTIONS: (Explain circled "Yes" answers below.)

- | | | |
|--|-----|----|
| 1. Had any recent injury, illness or infectious disease? | Yes | No |
| 2. Have a chronic or recurring illness/condition? | Yes | No |
| 3. Ever been hospitalized? | Yes | No |
| 4. Ever had surgery? | Yes | No |
| 5. Have frequent headaches? | Yes | No |
| 6. Ever had a head injury? | Yes | No |
| 7. Ever been knocked unconscious? | Yes | No |
| 8. Wear glasses, contacts or prescriptive eyewear? | Yes | No |
| 9. Frequent ear infections? | Yes | No |
| 10. Ever passed out during or after exercise? | Yes | No |
| 11. Ever had seizures? | Yes | No |
| 12. Ever had chest pain during or after exercise? | Yes | No |
| 13. Ever had high blood pressure? | Yes | No |
| 14. Ever been diagnosed with a heart murmur? | Yes | No |
| 15. Have diabetes? | Yes | No |
| 16. Have asthma? | Yes | No |
| 17. Had mononucleosis in the past twelve months? | Yes | No |
| 18. Ever had an eating disorder? | Yes | No |

Date of last Tetanus vaccine: _____ Are other immunizations current?: _____

Use this space to provide any additional information about the participant's health (mental, emotional and/or physical), which the camp/program director should be aware of:

Name of family physician: _____ Phone: () _____
Address: _____

This health history is correct and complete as far as I know, and the person herein has my permission to engage in all camp/program activities except as noted.

Signed: _____ **Print Name:** _____

Witness: _____ **Date:** _____