Medical Information Form

This form must be completed and returned prior to the first day of camp for your child to participate in the camp.

[ ] Mental or emotional health issue

[ ] Seizure disorder

[ ] Lung Disease (asthma, persistent cough, tuberculosis)

[ ] Disease of Heart or Blood Vessels, Increased or Abnormal Blood Pressure

[ ] Pain in Chest or Shortness of Breath (heart murmur, rheumatic fever)
Medical Form, Page 2 -- Camper Name:__________________________

[ ] Stomach or Intestinal Trouble (ulcers, gall bladder or liver disorder, jaundice, hernia, colitis)___________

[ ] Arthritis, Diabetes, Kidney or Bladder Disease________________________________________________________

[ ] Hay Fever or Allergies________________________________________________________

[ ] Impaired Sight or Hearing, Chronic Ear Infections____________________________________________________

[ ] Recent Surgical Operations, Accidents or Injuries_____________________________________________________

[ ] Any Current Infectious Disease______________________________________________________________

[ ] Any Current Skin Disease______________________________________________________________

[ ] Allergy to Foods________________________________________________________

[ ] Do You Wear Glasses? Yes [ ] No [ ] Sometimes [ ]

[ ] Do You Wear Contact Lenses? Yes [ ] No [ ]

[ ] Date of last TETANUS BOOSTER______________________________________________________________

[ ] Significant Orthopedic and/or Neuromuscular Impairment (e.g. loss of limb, spinal cord injury)__________

[ ] Any other current health related issues?____________________________________________________________

Please note: For residential camps, all medications that accompany the camper to camp will be given to a designated counselor/chaperone. The counselor will dispense the medication in accordance with the directions provided by the parent. Medication should be in its original container labeled by the pharmacist. Only include enough medication for the time the child will be attending the camp.

[ ] Medicines currently taken by camper, including non-prescription or over-the-counter medications (list names, doses, times)

____________________________________________________________________________________

____________________________________________________________________________________

[ ] Under on-going care of a Physician (NAME AND PHONE #) for chronic or recurring problem ______________

Family Doctor’s Name:__________________________ Clinic/Hospital:________________________

City:__________________________ Phone: (         )________________________

Health Insurance Provider Name ____________________________________________ Policy Number:________________________

As a parent or guardian, I understand that if a serious illness/injury develops, medical or hospital care will be given. I further understand that in case of serious illness/injury, I will be notified. However, if it is impossible to contact me, I give my permission for emergency treatment, x-ray or surgery, as recommended by an attending physician.

I also understand if my child becomes ill or injured, my health insurance is primary coverage for those expenses. The University of South Alabama carries accident insurance that is secondary coverage in the event of an injury.

SIGNED: ___________________________ DATE: ____________________________

( Parent or Guardian)