

SAINT MARY'S COLLEGE SUMMER PROGRAM HEALTH FORM

To be completed by Parent/Guardian

CAMP: _____ Fine Arts _____ Athletics _____ Summer Academy

Camper's Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

HEALTH HISTORY: (Confidential)

Does the camper have any conditions that we should be aware of to help insure that she has a positive experience at our program?

Yes No If yes, please explain: _____

Date of most recent tetanus toxoid immunization (must be within last 10 years) __/__/__

Allergies (food, medicine, insects, other) _____

List any current medications taken regularly, dosage, and reason for taking. (Medications brought to camp must be in original container and registered with medical staff.)

Medication	Dose	Time Taken	Reason for Taking

(Please add additional pages as needed)

HISTORY OF ILLNESSES:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> ADD or ADHD | <input type="checkbox"/> Depression | <input type="checkbox"/> Headaches | <input type="checkbox"/> Prior Athletic Injuries |
| <input type="checkbox"/> Allergies (food) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Recent Illness |
| <input type="checkbox"/> Allergies (medicine) | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Recent Injury |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bone/Joint Disease | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Menstrual Difficulties | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Emotional Difficulties | <input type="checkbox"/> Physical Limitations | <input type="checkbox"/> Restrictions: Special Problems |
| <input type="checkbox"/> Other | Please explain any items checked above in detail: | | |

EMERGENCY INFORMATION: Names and numbers at which parent(s) or guardian(s) can be reached while student is attending a SAINT MARY'S COLLEGE SUMMER PROGRAM.

_____	_____	_____	_____
Mother's (Guardian's) name	Home phone	Business phone	Cell Phone
_____	_____	_____	_____
Father's (Guardian's) name	Home phone	Business phone	Cell phone

If your insurance company requires you to identify a primary care physician for the student, please list the physician's name and contact information _____

This health history is correct to the best of my knowledge and my daughter has my permission to participate in camp activities with the exception of those noted above.* I authorize Saint Mary's college to release medical information regarding the above named participant to any medical treatment facility, parents, physician/health care provider.

Parent / Guardian Signature _____
Date