



**Summer Camper Health Form**

Name (please print): \_\_\_\_\_  
Last First

Birthday: \_\_\_\_\_

Sex: M F

Emergency contact (printed name & phone number):  
\_\_\_\_\_

Cell #: \_\_\_\_\_

Relationship of emergency contact to camper:  
\_\_\_\_\_

Race: \_\_\_\_\_

Conditions currently being treated or followed:  
\_\_\_\_\_  
\_\_\_\_\_

Surgeries/Hospitalizations/Serious Injuries/Disabilities:  
\_\_\_\_\_  
\_\_\_\_\_

Current medications (include OTC/herbal): \_\_\_\_\_  
\_\_\_\_\_

Which camp are you attending? \_\_\_\_\_ Date of camp: \_\_\_\_\_

**Camper Medical History**

- | Yes                      | No | If yes, specify:  |
|--------------------------|----|---|
|                          |    | Allergies to medications _____  |
|                          |    | Blood Disorders _____   |
|                          |    | Cancer _____  |
|                          |    | Diabetes _____  |
|                          |    | Gastrointestinal Problems _____<br>(e.g., hepatitis, colitis, ulcers) |
|                          |    | Heart Disease _____   |
|                          |    | High Blood Pressure _____   |
|                          |    | Kidney/Bladder Problems _____   |
|                          |    | Mental Health Problems _____<br>(e.g., depression, anxiety)           |
|                          |    | Respiratory Disease _____<br>(e.g., asthma, emphysema)                |
|                          |    | Seizure/Epilepsy _____  |
|                          |    | Skin Problems _____   |
|                          |    | Stroke _____  |
|                          |    | Thyroid Disease _____   |
|                          |    | Tuberculosis _____  |
|                          |    | Positive Tuberculin Skin test _____                                   |
| <input type="checkbox"/> |    | Other Medical Problems _____  |

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have health insurance?      \_\_\_\_\_ Yes                      \_\_\_\_\_ No

**Over-the-Counter Medication Release:** The ATU Health and Wellness Center has most over-the counter medications available. Please complete the following information. Medication will not be dispensed to campers without parental permission.

(Initial your preference)

\_\_\_\_\_ **DO NOT** give my child over-the-counter medications.

\_\_\_\_\_ **YES** you may provide over-the-counter medications **WITHOUT** a phone call to parent/guardian.

\_\_\_\_\_ **YES** but only after contacting parent/guardian. Contact #: \_\_\_\_\_

**Authorization for Medical Services:**

Permission is hereby granted to Health and Wellness Center at Arkansas Tech University to authorize medical services. In case of emergency, the Health and Wellness Center is authorized and requested to refer the student to a duly licensed physician, dentist or hospital, and such physician, dentist or hospital is authorized to administer such treatment or surgery as appears prudent under the circumstances then existing.

\*Note: During the summer (June 1st through July 31<sup>st</sup>), the Health and Wellness Center is staffed with one nurse practitioner and registered/practical nurses. There is no physician on-site. If it is not an emergency and your child requires more than basic first aid or authorized over-the-counter medications, a Health and Wellness Staff member will always attempt to contact the parent/guardian prior to providing any interventions. *If your child is diagnosed with a contagious illness, per CDC guidelines, it will be recommended that your child go home.* Please make sure that you have made arrangements for this potential situation and someone is available to pick them up.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

Alternate Contacts (i.e. grandparent, aunt, uncle, family friend) in case the parent/guardian cannot be reached:

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Phone number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Phone number: \_\_\_\_\_