

STOCKTON UNIVERSITY
MEDICAL FORM
2016 PERSONAL HEALTH AND MEDICAL RECORD

Participant/Camper Name _____

Date of Birth _____

Address _____

Age _____ Sex _____

City and State _____

Zip Code _____

IN CASE OF EMERGENCY, NOTIFY:

(Parents/Guardians should be the emergency contact, however, you may list other people if parent/guardian cannot be contacted.)

1. Name _____

Relationship _____

Address _____

Home Phone _____

City, State & Zip _____

Cellphone _____

Day Phone _____

2. Name _____

Relationship _____

Address _____

Home Phone _____

City, State & Zip _____

Cellphone _____

Day Phone _____

PHYSICIAN INFORMATION:

Name: _____

Phone: _____

Address: _____

City/State: _____

APPROVED FOR PARTICIPATION IN:

____ All Activities

____ Restricted Activities

____ Overnight stay in residential housing

Explain any medical restriction or limitations: _____

INSURANCE:

*Or provide copy of card

Name of Carrier _____

Policy Number _____

Group # _____

EMERGENCY MEDICAL INFORMATION:

Has or subject to: (check and give details)

____ Asthma

____ Heart Trouble

____ Convulsions

____ High Blood Pressure

____ Diabetes

____ Fainting Spells

____ Allergy or reaction to
any medicine, food, plant,
animal or other

____ Any other condition that may require
emergency or special care, medication or
knowledge:

____ Contact Lenses

Explain: _____

Each child attending must present documentation of immunizations or valid medical or religious exemption to vaccines.

****If we do not receive immunization information, your child will NOT BE CLEARED TO PARTICIPATE****

IMMUNIZATIONS:

MOST RECENT MONTH/DAY/YEAR:

DTP/DTaP (Diphtheria/Tetanus/Pertussis) _____
 OPV/IPV (Polio) _____
 MMR (Measles/Mumps/Rubella) _____
 Varivax/Varicella (Cpox) _____
 HBV (Hepatitis B) _____
 Meningococcal (For children ages 10+) _____

MEDICAL HISTORY:

Date of most recent physical exam: (month and year) _____

Are there any current health problems? No _____ Yes _____
 Is the Camper now under medical care or taking medications? No _____ Yes _____
 Will the Camper need medications administered during camp? No _____ Yes _____
 Has the Camper had any surgery, injury, illness, allergy, or change in health since last physical exam? No _____ Yes _____

Explain any "YES" answers (for medications, also complete Medication Authorization Form):

Is there Disease of (or past or present history of): (Each line must have a YES or NO answer)

	N/Y/Yr	Details		N/Y/Yr	Details
Serious Illness	_____	_____	Stomach, Bowels	_____	_____
Serious Injury	_____	_____	Appendicitis	_____	_____
Deformity	_____	_____	Kidneys or Urine	_____	_____
Surgery	_____	_____	Infection	_____	_____
Skin, Glands	_____	_____	Menstrual Problems	_____	_____
Ears, Eyes	_____	_____	Hernia Rupture	_____	_____
Nose, Sinus	_____	_____	Back, limbs, joints	_____	_____
Teeth, Tonsils	_____	_____	Sleepwalking	_____	_____
Dentures, Bridges	_____	_____	Behavioral Condition	_____	_____
Chest, Lungs	_____	_____	Murmur	_____	_____
Rheumatic Fever	_____	_____	Other (explain)	_____	_____

PARENT'S AUTHORIZATION:

To the best of my knowledge, the above medical history is correct and complete. I know of no reason to restrict applicant's activity, and give my permission for participation in all activities except as specifically noted herein. I understand that the responsibility for adequate sickness and accident insurance coverage rests solely with the parent/guardian.

In the event of a medical emergency, i.e., beyond basic first aid, the camper will be transported to the nearest medical facility for treatment. Based upon past experience, the medical facility will require the permission of the parent/guardian prior to treatment. If you wish the camp staff to make other arrangements, please state below:

_____ Date

_____ Signature of Parent/Guardian

Reviewed by Camp Health Director/Designee _____

_____ Signature

_____ Date

MEDICATIONS

MEDICATION AUTHORIZATION FORM

All Participants/Campers who will be taking **any** medication during camp must have a **Medication Authorization Form** on file with the Stockton Camp. Please fill the form out completely.

Without written authorization from a parent/guardian, we are not permitted to dispense any medication. Also note that only medication supplied by the parent/guardian may be dispensed. Please keep in mind that if your camper should need any type of medication once the camp has started, you will need to complete a Medication Authorization Form.

STORAGE

All prescription and over the counter medication must be stored at the Camp Office **in its original container**. Please put your child's name somewhere on the container. No camper is permitted to carry medication with them during camp. You may send the medication on a daily basis or send a supply that we will store at the Camp Office.

ASTHMA INHALERS

Any camper who needs or **may need** the use of an inhaler during sports camp must also have a Medication Authorization Form on file. We permit campers to keep their inhalers with them during camp. They may use their inhaler as needed under their Camp/Health Director's supervision.

If you should have any questions, please contact, Program/Camp/Health Director at [Stockton #](#).

Note: *Campers/Participants do not need a medical authorization form for bug spray or sunscreen.*

MEDICATION AUTHORIZATION FORM

**** ALL MEDICATIONS MUST BE STORED IN THEIR ORIGINAL CONTAINERS ****
(Form must be filled out completely)

(Please Print)

CHILD'S NAME: _____

GROUP (IF KNOWN): _____

NAME OF MEDICATION: _____

PRECAUTIONARY INFORMATION/SIDE EFFECTS: _____

CONDITION FOR USE: _____

INSTRUCTIONS FOR ADMINISTRATION: _____

I AUTHORIZE THE STOCKTON PROGRAMCAMP TO ADMINISTER THIS MEDICATION

DATE

PARENT/GUARDIAN SIGNATURE

PHONE #

PARENT/GUARDIAN'S NAME (please print)