2020 Dabo Swinney Football Camp Health History Form

To Parent(s)/Guardian(s): Please follow the instructions below: Attach additional information if needed.

Participant Name: _____
Last *First* *Middle Initial*

Dates will attend camp/program: from _____ to _____
Month/Day/Year *Month/Day/Year*

Birth Date: _____ Sex: _____ Age on arrival at camp/program: _____
Month/Day/Year

Participants Home Address: _____
Street & Number *City* *State* *Zip*

Parent or Guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship: _____ Preferred Phone:(____)_____ (____)_____
Email: _____

Home Address: _____
Street & Number *City* *State* *Zip*

Second parent/guardian or other emergency contact:

Name: _____ Relationship: _____ Preferred Phone:(____)_____ (____)_____
Email: _____

Additional contact in event parents(s)/guardian(s) can not be reached:

Name: _____ Relationship: _____ Preferred Phone:(____)_____ (____)_____
Email: _____

Allergies: ☐ No Known Allergies.

☐ This participant is Allergic to:
- ☐ To Foods ***(list)*** _____ Reaction:_____
- ☐ To Medications ***(list)*** _____ Reaction: _____
- ☐ To the environment ***(Insect Stings, Hay Fever, etc. -list)*** _____ Reaction: _____
- ☐ Other ***(list)*** _____Reaction: _____

Diet, Nutrition: ☐ This camper eats a regular diet. ☐ This camper eats a regular vegetarian diet. ☐ This camper is Lactose intolerant. ☐ This camper is gluten intolerant: ☐ Other, **please explain in space.**

Restrictions:

☐ I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.

☐ I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations:
(Please describe below)

Medical Insurance Information:

PLEASE PROVIDE A COPY OF THE INSURANCE CARD FOR THE PARTICIPATING CAMPER

Health Care Providers:

Name of participants primary doctor:_____ Phone: (___)_____

Name of dentist:_____ Phone: (___)_____

PARENT AUTHORIZATION & PERMISSION TO TREAT:

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by me and the examining physician. I hereby give permission to the medical personnel selected by the camp director to provide routine health care: to administer medications; 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/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above.

Parent/Guardian Signature_____ **Date**_____ **Relationship to participant:** _____

Participant Name: _____
Last *First* *Middle Initial*

Medication: ☐ This camper takes NO medications on a routine basis
☐ This camper takes medications as follows (attach additional pages if needed)

Medication & Dose given:	Dosage:	Times taken each day:	Reason for taking:

Non-prescription medications may be stocked by the camp/program and are used on an ***as needed basis*** to manage illness and injury. **Please list any non-prescription medications that the participant should *not* be given.**

Health History: Check "yes" or "no" for each statement. Explain, "yes" answers below.
Has/does the camper:

1. Ever been hospitalized? □ Yes □ No
2. Ever had surgery? □ Yes □ No
3. Have recurrent/chronic illness? □ Yes □ No
4. Had recent infections disease? □ Yes □ No
5. Had recent injury? □ Yes □ No
6. Have diabetes? □ Yes □ No
7. Had seizures? □ Yes □ No
8. Had headaches? □ Yes □ No
9. Have history of bedwetting? □ Yes □ No
10. Have any skin problems? □ Yes □ No
11. Wear glasses, contacts, or protective eyewear? □ Yes □ No
12. Had fainting or dizziness? □ Yes □ No
13. Ever had back/joint problems? □ Yes □ No
14. Passed out/had chest pain during exercise? □ Yes □ No
15. Have problem with falling asleep/sleepwalking? □ Yes □ No
16. Had mononucleosis during the past 12 months? □ Yes □ No
17. If female, have problems with periods/menstruation? □ Yes □ No
18. Have problems with diarrhea/constipation? □ Yes □ No
19. Had asthma/wheezing/shortness of breath? □ Yes □ No
20. Travel outside the country in the past 9 months? □ Yes □ No

Please explain "yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.
_____
_____
_____
_____
_____

Immunization History: ☐ Participant has been fully immunized with all up to date immunizations required for school.
☐ Participant has not been fully immunized. By signing below, I understand and accept the risks to my child from not being fully immunized.

Signature of Custodial Parent/Guardian: _____ Date: _____ Relationship to Participant _____

Tetanus or Tetanus Booster (dT) or (TdaP) Most Recent Dose _____
Month/Year

Mental, Emotional, and Social Health: Check "yes" or "no" for each statement.
Has the participant:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐Yes ☐No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐No
4. Had a significant life event that continues to affect the participant's life? ☐ Yes ☐No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp/program may contact you for additional information.