

ATU HEALTH & WELLNESS CENTER

Summer Camp Form

Name (please print): _____
Last First

Birthday: _____

Sex: M F Other (please specify) _____

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? _____

Camper Medical History

Yes	No		If yes, specify
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to medications	_____
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Problems (e.g., hepatitis, colitis, ulcers)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder Problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Problems (e.g., depression, anxiety)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease (e.g., asthma, emphysema)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Seizure/Epilepsy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Positive Tuberculin Skin test	_____
<input type="checkbox"/>	<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 31st), the Health and Wellness Center is staffed with one APRN, two RNs, and one LPN. There is no physician on-site.

If it is not an emergency and your child requires more than just basic first aid or authorized over-the-counter medications then a Health and Wellness Staff member will always attempt to contact the parent/guardian prior to providing any interventions.

Signature of Parent or Guardian

Date

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

Name: _____ Relationship to student: _____

Phone number: _____