ATU HEALTH & WELLNESS CENTER

CAMPER HEALTH HISTORY

Camper Full Name (print):_____ DOB :_____ Date:_____

Parent phone #:_____ Camper phone #:_____ Sex: M__ F__ Race:_____

Gender: Male__ Female__ Transfemale__ Transmale__ Genderqueer/nonconforming__ Other _____ Decline __

Emergency contact #:_____ Relationship to camper:_____

Allergies (medication):_____

Camper health conditions currently being managed:_____

Camper surgeries/hospitalizations/serious injuries/disabilities: _____

Current medications (include OTC/herbal):_____

Which camp is being attended? _____

Medical History

Camper				Family		
Yes	No	Specify		Yes	No	Relationship/Specify
☐	☐	_____	Allergies	☐	☐	_____
☐	☐	_____	Blood Disorders	☐	☐	_____
☐	☐	_____	Cancer	☐	☐	_____
☐	☐	_____	Diabetes	☐	☐	_____
☐	☐	_____	Gastrointestinal Problems (e.g., hepatitis, colitis, ulcers)	☐	☐	_____
☐	☐	_____	Heart Disease	☐	☐	_____
☐	☐	_____	High Blood Pressure	☐	☐	_____
☐	☐	_____	Kidney/Bladder Problems	☐	☐	_____
☐	☐	_____	Mental Health Problems (e.g., depression, anxiety)	☐	☐	_____
☐	☐	_____	Respiratory Disease (e.g., asthma, emphysema)	☐	☐	_____
☐	☐	_____	Seizure/Epilepsy	☐	☐	_____
☐	☐	_____	Skin Problems	☐	☐	_____
☐	☐	_____	Stroke	☐	☐	_____
☐	☐	_____	Thyroid Disease	☐	☐	_____
☐	☐	_____	Tuberculosis	☐	☐	_____
☐	☐	_____	Positive Tuberculin Skin Test	☐	☐	_____
☐	☐	_____	Other Medical Problems	☐	☐	_____

Comments:_____

_____

Does the camper have health insurance? Yes_____ No_____

Has the camper been fully vaccinated for COVID19? Yes_____ No_____ Date:_____

Authorization for Medical Procedures:

Permission is hereby granted to Health and Wellness Center at Arkansas Tech University to authorize medical services, including physician ordered injections or required immunizations. 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.

May we provide the student with over the counter medications as recommended by our medical staff?
□ yes, you may provide OTC medications without a phone call to parent/guardian
□ yes, only after calling to discuss with parent/guardian phone #:_____
□ no

This document is used for evaluating the physical and emotional condition of each student so that the Health and Wellness Center can meet the student's needs. **THIS IS A CONFIDENTIAL COMMUNICATION** between the student, parent, and the Health and Wellness Center. Information herein will not be transmitted to anyone without the written consent of the student/parent. To the best of my knowledge the information submitted is complete and accurate.

_____ _____
Signature of Student Date

_____ _____
Signature of Parent or Guardian Date