

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

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

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