

# SUMMER BAND CAMP MEDICAL HISTORY REPORT

Forest Hills Central High School

August 1 - 6, 2010

**IMPORTANT:** This form must be completed in full and signed by both participant and parent before participation in camp will be allowed. A doctor's signature is not required.

## A MESSAGE TO YOU CONCERNING YOUR HEALTH:

It is the aim of Central Michigan University to have each camper enjoy as complete an experience as is possible within his or her physical and mental ability. Your medical history will provide the essential information needed to meet the goal. The history is required primarily to determine what adjustments, if any, must be made in schedules of activities to meet the individual needs of campers. This form will be kept on file by CMU camp personnel to be used in the event of injury or illness or planning for camp participation.

Participation in the youth camp is at the sole discretion and judgment of the participants and at their own risk. The participant and the participant's parent or guardian assumes full responsibility for any injuries or damage that may occur. The participant and the participant's parent or guardian hereby release and agree to hold harmless CMU, its Board of Trustees, students and employees from all claims, action, damages, and liabilities for personal injury or damage relating to or arising out of any youth camp activity except where the injury or damage is caused by negligence of the university, its agents or employees.

LAST NAME, FIRST, MIDDLE (PLEASE PRINT)	U.S. SOCIAL SECURITY NUMBER (for emergency use)
HOME STREET ADDRESS	AGE      BIRTHDATE
HOME CITY, STATE, ZIP	HOME TELEPHONE (    )

## IN CASE OF EMERGENCY CONTACT:

LAST NAME, FIRST, MIDDLE	RELATIONSHIP	HOME TELEPHONE (    )
STREET ADDRESS	BUSINESS ADDRESS	
CITY, STATE, ZIP	CITY	BUSINESS TELEPHONE (    )

## PERSONAL HISTORY - MARK WITH AN "X" IN THE BOXES BELOW THOSE MEDICAL PROBLEMS YOU HAVE HAD OR THOSE YOU NOW HAVE

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Scarlet Fever<br><input type="checkbox"/> Measles<br><input type="checkbox"/> German Measles<br><input type="checkbox"/> Mumps<br><input type="checkbox"/> Chicken Pox<br><input type="checkbox"/> Malaria<br><input type="checkbox"/> Gum or Tooth Problems<br><input type="checkbox"/> Sinusitis<br><input type="checkbox"/> Eye Problems<br><input type="checkbox"/> Glasses<br><input type="checkbox"/> Contacts<br><input type="checkbox"/> Ear, Nose, Throat Problems<br><input type="checkbox"/> Sickle Cell Anemia<br><input type="checkbox"/> Pneumonia<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Pleurisy<br><input type="checkbox"/> Hypoglycemia<br><input type="checkbox"/> Trick Knee, Shoulder, etc<br><input type="checkbox"/> Immune System Disorder<br><input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Cancer<br><input type="checkbox"/> Seizures<br><input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Recent Weight Gain or Loss<br><input type="checkbox"/> Insomnia<br><input type="checkbox"/> Frequent Anxiety<br><input type="checkbox"/> Frequent Depression<br><input type="checkbox"/> Worry or Nervousness<br><input type="checkbox"/> Recurrent Headaches<br><input type="checkbox"/> Recurrent Colds<br><input type="checkbox"/> Head Injury w/ Unconsciousness<br><input type="checkbox"/> Hay Fever<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Shortness of Breath<br><input type="checkbox"/> Allergy<br><input type="checkbox"/> Penicillin<br><input type="checkbox"/> Sulfa<br><input type="checkbox"/> Serum<br><input type="checkbox"/> Foods<br><input type="checkbox"/> Other (specify) | <input type="checkbox"/> Protein/Sugar in Urine<br><input type="checkbox"/> Jaundice, Liver Problems<br><input type="checkbox"/> Stomach or Intestinal Problems<br><input type="checkbox"/> Dizziness, Fainting<br><input type="checkbox"/> Pain/pressure in Chest<br><input type="checkbox"/> Chronic Cough<br><input type="checkbox"/> Palpitations<br><input type="checkbox"/> High or Low Blood Pressure<br><input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> Heart Problem or Disease<br><input type="checkbox"/> Joint Disease or Injury<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Ankle Sprains & Knee Injuries<br><input type="checkbox"/> Mild <input type="checkbox"/> Mild<br><input type="checkbox"/> Severe <input type="checkbox"/> Severe<br><input type="checkbox"/> Cholesterol Problems<br><input type="checkbox"/> Back Problems<br><input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Surgery<br><input type="checkbox"/> Appendectomy<br><input type="checkbox"/> Tonsillectomy<br><input type="checkbox"/> Hernia Repair<br><input type="checkbox"/> Other (specify)<br><input type="checkbox"/> Gallbladder Problem or Gallstones<br><input type="checkbox"/> Recurrent Diarrhea<br><input type="checkbox"/> Rupture, Hernia<br><input type="checkbox"/> Weakness, Paralysis<br><input type="checkbox"/> Frequent Urination<br><br><b>FEMALES ONLY:</b><br><input type="checkbox"/> Irregular Periods<br><input type="checkbox"/> Severe Cramps<br><input type="checkbox"/> Excessive Flow<br><input type="checkbox"/> Other (specify) |
|--|---|--|--|

**PERSONAL HISTORY CONTINUED**

PLEASE ANSWER ALL QUESTIONS BY MARKING AN "X" IN THE "YES" OR "NO" COLUMN. COMMENT ON ALL "YES" RESPONSES IN THE SPACE BELOW. USE ADDITIONAL SHEET IF NECESSARY.

	YES	NO
1. Has your physical activity been restricted during the past five years? (Give reasons and duration)		
2. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? (Give details)		
3. Have you had any illness or injury or been hospitalized other than already noted? (Give details)		
4. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (Other than routine checkups?)		
5. Do you have any health problem that requires periodic evaluation or testing? (Give details)		
6. Are you now under medication or treatment? (List medication, dosage, type of treatment in space below)		
7. If you use needles (syringes) for medications, please check here so that we may have a puncture resistant container available for your use.		

CONTINUING MEDICATIONS USE THIS SPACE FOR RESPONDING TO QUESTION NO.7 ABOVE.) (Medications that are required by participants should accompany them at camp.)	DATE STARTED

IMMUNIZATION HISTORY SUPPLY THE DATE FOR EACH OF THOSE WHICH YOU HAVE HAD			
	DATE		DATE
Diphtheria, Tetanus, Pertussis		Pneumococcal	
Haemophilus Influenza Type B (HIB)		Varicella	
Hepatitis B Vaccine		Influenza *	
Inactivated Polio (IPV)		Hepatitis A *	
Measles, Mumps, Rubella (MMR)		Other (Specify)	

*This schedule includes the recommended childhood vaccines, as of December 1, 2001, for children through 18 years.  
\*Indicates vaccines recommended for selected populations.*

**HEALTH INSURANCE COVERAGE: CHECK ALL THAT APPLY**

Note: University Health Services will bill your primary health insurance company if you provide authorization to do so and present current plan enrollment information. Upon request, Health Services will provide an itemized statement for submission to a secondary plan. If you belong to an HMO or PPO, you must obtain pre-authorization for care for your child from your health insurance carrier prior to receiving services. The health insurance plan will reimburse you directly for any covered benefits. You remain responsible for payment of the total amount of the charges incurred at Health Services. For additional information contact the Health Services Business Office at 774-6599.

<input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> MESSA <input type="checkbox"/> HMO/PPO (plan name) <input type="checkbox"/> Student Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Other (specify) <input type="checkbox"/> None	SUBSCRIBER'S NAME (print)
	RELATIONSHIP TO STUDENT
	ADDRESS
	POLICY/CONTRACT NUMBERS
	PLAN PHONE NUMBER (if pre-authorization is required for care)

<b>STUDENT - PLEASE SIGN BELOW AND RETURN TO:</b> <b>Students - Please sign below, make sure your parent(s) or guardian sign below and return this form to your band director.</b>		<b>PARENT OR GUARDIAN</b> I hereby give my permission for such necessary and emergency care to be given <i>my</i> son or daughter at the university Health Services. CMU: Central Michigan Community Hospital. Mount Pleasant, MI: and attending CMU Staff. <i>(To be signed by parent or guardian for al/ applicants under 18 years of age.)</i>	
SIGNATURE OF STUDENT	DATE	SIGNATURE OF PARENT OR GARDIAN	DATE
DATE OF LAST PHYSICAL EXAMINATION _____			
<b>STUDENT/PARENT/GUARDIAN PLEASE SIGN AND RETURN</b>			