

SUMMER BAND CAMP MEDICAL HISTORY REPORT

Forest Hills Central High School
August 2 - 7, 2009

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 judgement of the participants and at their own risk. The participant and the participant's parent or guardian assume 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 <i>(for emergency use)</i>
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
<input type="checkbox"/> Measles
<input type="checkbox"/> German Measles
<input type="checkbox"/> Mumps
<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Malaria
<input type="checkbox"/> Gum or Tooth Problems
<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Eye Problems
<input type="checkbox"/> Glasses
<input type="checkbox"/> Contacts
<input type="checkbox"/> Ear, Nose, Throat Problems
<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Trick Knee,
Shoulder, etc.
<input type="checkbox"/> Immune System Disorder
<input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Cancer
<input type="checkbox"/> Seizures
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Recent Weight Gain or Loss
<input type="checkbox"/> Insomnia
<input type="checkbox"/> Frequent Anxiety
<input type="checkbox"/> Frequent Depression
<input type="checkbox"/> Worry or Nervousness
<input type="checkbox"/> Recurrent Headaches
<input type="checkbox"/> Recurrent Colds
<input type="checkbox"/> Head Injury w/
Unconsciousness
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Asthma
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Allergy
<input type="checkbox"/> Penicillin
<input type="checkbox"/> Sulfa
<input type="checkbox"/> Serum
<input type="checkbox"/> Foods
<input type="checkbox"/> Other (specify) | <input type="checkbox"/> Protein/Sugar in Urine
<input type="checkbox"/> Jaundice, Liver Problems
<input type="checkbox"/> Stomach or
Intestinal Problems
<input type="checkbox"/> Dizziness, Fainting
<input type="checkbox"/> Pain/Pressure in
Chest
<input type="checkbox"/> Chronic Cough
<input type="checkbox"/> Palpitations
<input type="checkbox"/> High or Low Blood
Pressure
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Heart Problem or Disease
<input type="checkbox"/> Joint Disease or Injury
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Ankle Sprains & Knee Injuries
<input type="checkbox"/> Mild <input type="checkbox"/> Mild
<input type="checkbox"/> Severe <input type="checkbox"/> Severe
<input type="checkbox"/> Cholesterol Problems
<input type="checkbox"/> Back Problems
<input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Surgery
<input type="checkbox"/> Appendectomy
<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Hernia Repair
<input type="checkbox"/> Other (specify)
<input type="checkbox"/> Gallbladder Problem
or Gallstones
<input type="checkbox"/> Recurrent Diarrhea
<input type="checkbox"/> Rupture, Hernia
<input type="checkbox"/> Weakness, Paralysis
<input type="checkbox"/> Frequent Urination

FEMALES ONLY:
<input type="checkbox"/> Irregular Periods
<input type="checkbox"/> Severe Cramps
<input type="checkbox"/> Excessive Flow
<input type="checkbox"/> Other (specify) |
|--|--|---|---|

