

SANTA CLARA UNIVERSITY CAMPS & CLINICS MEDICAL HISTORY/CONSENT AND INSURANCE INFORMATION

Each camper must have this form on file before participating in any camp activities.

Camper Name: _____
Last First Middle

Birthday: _____ Age: _____ Sex: _____

Parent or Guardian: _____

Home Address: _____
Number/Street City St. Zip

Home Phone: _____ Work Phone: _____

If not available in an emergency, please notify:

1. _____ Phone: _____ Relationship: _____

2. _____ Phone: _____ Relationship: _____

HEALTH HISTORY

Has/Does the participant:	No	Yes	If "yes", please explain.
1. have a current injury/illness/infectious disease?	No	Yes	_____
2. have a chronic or recurring illness/condition?	No	Yes	_____
3. ever been hospitalized?	No	Yes	_____
4. ever had seizures/convulsions?	No	Yes	_____
5. have diabetes?	No	Yes	_____
6. have asthma?	No	Yes	_____
7. have allergies/	No	Yes	_____
8. had mononucleosis in the past 12 months?	No	Yes	_____

Medications Currently Being Taken: (include both over-the-counter and prescription medications)

This participant takes NO medications on routine basis.

This participant takes medications as follows:

Med. #1 _____ specific times taken _____
reason for taking _____ dosage _____.

Med #2 _____ specific times taken _____
reason for taking _____ dosage _____.

Attach additional pages for more medications.

Please list any restrictions for this participant while at the camp/clinic.

