

# Vanderbilt University Summer Camp Medical Forms

\*Entire Page to Be Completed By Patient

## Personal History

_____	Male _____	Female _____	_____ / _____ / _____
Name	Sex	Age	Date of Birth
_____	_____		
School	Name of Camp Attending		
_____	_____	_____	
Parent/Guardian Name	Cell Phone	Work/Home Phone	
_____	_____	_____	
Secondary Contact Name	Relationship	Cell Phone	Work/Home Phone
_____	_____	_____	_____
_____	_____		
Personal Physician Name	Physician Phone Number		
_____	_____		
_____	_____	_____	_____
Insurance Company Name	Policy Number	Group Number	Phone

## Medical History

Please explain "Yes" answers below.

	Yes	No
1. Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you presently taking any medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies (medicine, bees or other stinging insects, Shellfish, nuts)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you every passed out during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had chest pain during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever been told that you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has anyone in your family died of heart problems or a sudden death before the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever had heat or muscle cramps?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever been dizzy or passed out in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you have trouble breathing or do you cough during or after activities?	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you wear glasses or contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you ever had any other medical problem (infectious mononucleosis, diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you ever had a medical problem since your last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>
21. When was your last tetanus shot? _____		

Please explain "yes" answers here:

I herby state that, to the best of my knowledge, my answers to the above questions are correct.

\_\_\_\_\_  
Signature of Athlete

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date