

Clarkson University Summer Youth Programs
MEDICAL HISTORY REPORT

ALL PROGRAM PARTICIPANTS MUST HAVE A COMPLETED AND APPROVED MEDICAL HISTORY REPORT ON FILE AT CLARKSON PRIOR TO ARRIVAL ON CAMPUS. All information on this form is kept confidential and used only by camp directors and health personnel. Completed forms and attachments should be sent to: The Clarkson School, Box 5650, Potsdam, NY 13699-5650, by June 30, 2009.

Program: _____ **Dates of Camp Attendance:** _____

Directions: Please type or print clearly in ink. This form is to be completed by a parent or guardian. **EVERY** section must be filled in completely. Please write N/A if not applicable. Do not leave blanks.

Section 1: Basic information

Participant's Name: _____ DOB: _____ Sex: _____
Last First MI MM/DD/YYYY

Participant's Social Security #: _____ Age at camp: _____

Home Address: _____
Street

City State Zip

Home Phone #: () _____

Primary Guardian: Mother Father Both Other

Father/Guardian's Name: _____

Address (if different than above): _____

Home Phone #: () _____ Work #: () _____ Mobile #: () _____

Mother/Guardian's Name: _____

Address (if different than above): _____

Home Phone #: () _____ Work #: () _____ Mobile #: () _____

Section 2: Emergency Notification

Specify a READILY ACCESSIBLE individual to be notified if above parents/guardians aren't available. This person must be an adult different from the persons listed above. Parent/guardian contacts will be attempted first.

Name: _____ Relationship: _____

Address: _____
Street City State Zip

Home Phone #: () _____ Work #: () _____ Mobile #: () _____

Section 3: Parent/Guardian Confirmation of Medical Health Report and Authorization to Participate in Program

This medical health report (pages 1 – 5) is correct and complete to the best of my knowledge, and my child has permission to engage in all prescribed program activities, except as noted by me. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I hereby give my permission for routine medical treatment of illness and injury at the Clarkson University Summer Youth Program Infirmary, with a physician if needed, and for routine emergency medical treatment at Canton-Potsdam Hospital or regional medical center if referred by Canton-Potsdam Hospital. If prescriptions are obtained for my child during camp, I agree to reimburse Clarkson University for any payments made for them.

Print Parent/Guardian Name: _____

Signature: _____ **Date:** _____

Clarkson University Summer Youth Programs
MEDICAL HISTORY REPORT

Section 4: Immunization Record

*Immunizations are required by the New York State Health Department. Participants cannot be admitted to the program without these dates being **filled in completely**. Writing **“up to date”** is **not acceptable**. If photocopies of records are included, check the **“SEE ATTACHED”** Box.*

SEE ATTACHED (please staple a copy of the immunization record to this form)

IMMUNIZATION DATES (mo/yr)				
DPT	1. _____	2. _____	3. _____	4. _____ 5. _____
Tetanus/diphtheria (DT)	1. _____ (Date within last 10 yrs.)			
OPV (polio)	1. _____	2. _____	3. _____	4. _____
Measles	1. _____	2. _____	<i>(May be given as MMR</i>	
Mumps	1. _____	2. _____	<i>#1 must be given on/after</i>	
Rubella	1. _____	2. _____	<i>12 months of age)</i>	
Hepatitis B	1. _____	2. _____	3. _____	
Varicella (Chicken Pox)	1. _____	2. _____		
Haemophilus Influenza	1. _____	2. _____	3. _____	4. _____
Which of the following has the participant had?			Date of Last TB Test (if any): _____	
<input type="checkbox"/> Measles	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Mumps	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	

Additional Information (if any):

Section 5: Health Insurance

Health insurance is required for ALL participants. Insurance claims are handled by the family and the respective insurance company. If the participant will not have coverage during their length of stay at Clarkson University, it **MUST** be purchased and proof of insurance provided. Please **attach a copy of the insurance card and prescription card if available.**

Insurance Company _____ ID # _____

Subscriber's Name _____ Group # _____

City of Company _____ Relationship of participant to subscriber _____

Clarkson University Summer Youth Programs
MEDICAL HISTORY REPORT

PAGE 3

Participant's Name: _____
Last First MI

Participant's Social Security #: _____

Section 6: Health History

Please answer **each** of the following questions (yes/no) and elaborate in the spaces provided.

Does the participant have (or ever had) the following?

Condition	Y	N	Explain (what, how long, present condition, reaction, etc.)
Allergies*			
Asthma			
ADHD			
Diabetes			
Dietary concerns/restrictions			
Epilepsy			
Physical disabilities			
Major illness/condition			
Mental/psychological illness			
Glasses/contact lenses			
Other pertinent medical history			

*If yes, will he/she need allergy injections during the duration of camp participation? Yes No

If female, has she begun menstruation? Yes No

ADDITIONAL SPACE FOR MEDICAL HISTORY INFORMATION:

Clarkson University Summer Youth Programs
MEDICAL HISTORY REPORT

PAGE 4

Section 7 - Parent/Guardian and Health Care Provider's Individualized Orders Authorization Regarding Medications

Participant's Name: _____
Last First MI

Participant's Social Security #: _____

This section covers both medications (prescription and over-the counter) brought by your child to campus and over-the counter medications available for dispensing through our infirmary on campus. **The dispensing of ALL medications must be authorized by BOTH the parent/guardian AND the child's medical provider on pages 3 and 4 of this form. If these authorizations are not present, medications will NOT be dispensed.**

A. What will be brought to Clarkson University

Please list all medications your child takes (prescription **and** over-the-counter) and will be bringing to camp. Include both "scheduled" and "as needed" medications. These medications must be kept in their original packaging/bottle that identifies the name of the medication, the dosage, the frequency of administration, and the prescribing doctor (if applicable). **ALL medications are turned over to the medical staff upon arrival to campus (except items such as Epi-Pens and inhalers as noted previously) and are secured and dispensed by the medical staff.**

Drug Name	Route	Dosage	Schedule & Indications	Reason	Comments

Health Care Provider Authorization for Above Medications (prescription and over-the-counter):

Health Care Provider Name: _____ Phone#: _____
 Address: _____ License#: _____
 Health Care Provider Signature: _____ Date: _____

Parent/Guardian Authorization:

I give permission for my child, _____, to receive the medication(s) as prescribed/authorized above by our licensed health care provider. The prescribed medications listed are to be provided by me in the properly labeled original containers from the pharmacy. I understand that my child will have all medications administered to them by the Clarkson University Summer Youth Program Medical Staff. I understand that all medications are secured by the Clarkson University Summer Youth Program Medical Staff, with the exception of severe medical condition authorizations, such as the use of Epi-Pens, rescue inhalers, and/or other medications at the discretion of the Medical Staff. **Parents will be notified and campers may be sent home if they are found in possession of any medication without proper authorization.**

Parent/Guardian Signature: _____ Date: _____

Clarkson University Summer Youth Programs
MEDICAL HISTORY REPORT

PAGE 5

Participant's Name: _____
Last
First
MI

Participant's Social Security #: _____

B. Medications available through the Clarkson University youth program infirmary: The over-the-counter medications listed below are retained and dispensed by Clarkson's Summer Youth Program Medical Staff. **BOTH parents/guardians AND the health care provider must authorize the dispensing of these medications.**

Drug Name	Preferred Route (circle preferred formulation if applicable)	Dosage	Schedule & Indications (not to exceed recommended daily dose)	Authorization?	Comments
Tylenol	PO (chewable tabs, elixir, tabs)	Per label instructions by age/weight	Q4hr prn, for pain or fever > ____°F	Yes No	
Ibuprofen	PO (chewable tabs, suspension, tabs)	Per label instructions by age/weight	Q4-6hrs prn, for pain or fever > ____°F	Yes No	
Benadryl	PO (elixir, chewable tabs, pills)	Per label instructions by age/weight	Q6hr prn for allergic reaction	Yes No	
Children's Mylanta	PO (chewable tabs)	Per label instructions by age/weight	BID-TID prn for stomach upset	Yes No	
Dramamine	PO (chewable 50mg tab)	Per label instructions by age/weight	Q6-8hrs prn for motion sickness	Yes No	
Dimetapp	PO (elixir, tabs)	Per label instructions by age/weight	Q6-8hrs prn for nasal congestion/drainage	Yes No	
Midol	PO (caplets, tabs)	Per label instructions by age/weight	Q6hr prn for menstrual cramping and discomfort	Yes No	
Pepto-Bismol	PO (liquid, chewable tabs)	Per label instructions by age/weight	Q30min – 1hr, prn for diarrhea	Yes No	
Robitussin	PO (syrup)	Per label instructions by age/weight	Q4hr prn, for cough	Yes No	
Tums	PO (tablet)	Per label instructions by age/weight	Q1hr, prn for upset stomach related to indigestion	Yes No	

Health Care Provider Authorization for Above Medications (prescription and over-the-counter):

Provider Name: _____ Phone#: _____ License # _____

Address: _____

Health Care Provider Signature: _____ Date: _____

Parent/Guardian Authorization: I give permission for my child, _____, to receive the medication(s) as prescribed/authorized above by our licensed health care provider. The prescribed medications listed are to be provided by me in the properly labeled original containers from the pharmacy. I understand that my child will have all medications administered to them by the Clarkson University Summer Youth Program Medical Staff. I understand that all medications are secured by the Clarkson University Summer Youth Program Medical Staff, with the exception of severe medical condition authorizations, such as the use of Epi-Pens, rescue inhalers, and/or other medications at the discretion of the Medical Staff. **Parents will be notified and campers may be sent home if they are found in possession of any medication without proper authorization.**

Parent/Guardian Signature: _____ Date: _____

Clarkson University Summer Youth Programs
MEDICAL HISTORY REPORT

PAGE 6

FOR OFFICE USE ONLY – INFIRMARY NOTES

Date Received: _____

Date Reviewed: _____

Reviewed By: _____

Issues to Follow Up With:

Follow-Up Results: