Summer Program Medical Form

Susquehanna University
Office of Event Management
514 University Ave, Selinsgrove, PA 17870
Phone: 570-372-4451 • Email: summerprograms@susqu.edu

This medical form is kept confidential and used by our staff or medical personnel. The information on this form is gathered to assist us in identifying appropriate care. **Every student must have a completed medical form in order to participate in any Summer Pre-College Program. Please fill out this form to the best of your knowledge.** Email your completed form to summerprograms@susqu.edu or mail to Susquehanna University using the address above.

Student Information:

Susquehanna Summer Program Attending: ________________________________ Date(s): _________________________

Student's Name: ____ Preferred Name: _________________________

Birthdate: ________________________Age at Camp: _______________________ Last Grade Completed: _____________

Home Address: ____

Parent/Guardian Information:

Parent/Guardian Name: ____

Home Address: ____

Home Phone: _______________________ Cell Phone: _______________________ Work Phone: _____________________

Second Parent/Guardian Name: ____

Home Address: ____

Home Phone: _______________________ Cell Phone: _______________________ Work Phone: _____________________

Is there anyone else that is authorized to pick up this student? ❒ YES ❒ NO

Name(s), Phone Number(s), Relationship to Student: ____

____

*In the case of an emergency, parents/guardians will be contacted first. Please provide an emergency contact in case the parents/guardians cannot be reached.

Emergency Contact Name: ____

Home Phone: _______________________ Cell Phone: _______________________ Work Phone: _____________________

Allergy Information:

Medication Allergies (list) Describe reaction and management of the reaction

______________________ ____

______________________ ____

Food Allergies (list) Describe reaction and management of the reaction

______________________ ____

______________________ ____

Other allergies (list) Include insect stings, hay fever, asthma, plant allergies, detergents, animals, etc.

______________________ ____

______________________ ____

Attach additional pages for more allergens.

Medication Information:

Will it be necessary for the student to take any medication while at Susquehanna University? ❒ YES ❒ NO

If yes, list medication(s) below:

Medication ____________ Dosage __________ Time of Administration ________ Reason for taking ________________

Medication ____________ Dosage __________ Time of Administration ________ Reason for taking ________________

Medication ____________ Dosage __________ Time of Administration ________ Reason for taking ________________

Attach additional pages for more medications

If the student requires medication on a regular basis, do you give the student permission to take medication as prescribed without adult supervision? ❒ YES ❒ NO.

Prescription medication must be in its original container labeled by the pharmacist or prescriber. Label must include name, address, phone number for pharmacist or prescriber, and administration directions. Containers must hold only the amount required for the time the participant will be attending the program. Controlled substances including ADHD and ADD medications, psychiatric medications, and some hormones will be required to be stored in the medication lockbox, located in the Office of Event Management in the Degestein Campus Center. Participants must hand these medications over to program staff at check-in and come to the Office of Event Management to receive these medications. Medications stored in the medication lockbox will be returned to participants at check-out. Participants and parents/guardians will be notified prior to the start of the program if a participant's medication is required to be stored in the medication lockbox.

I am aware that I may NOT share any medications with other participants or staff.

Camper signature: ____ Date: ________________

Immunization History:

What is the date of the student's last tetanus shot (required within the last 10 years) _______________________________

Additionally, please attach the most recent immunization history report from your medical provider to the end of this form. This must be included in order to consider this form complete.

General Questions:

Has/does the participant:	YES	NO
1. Had a recent injury, illness, or infectious disease?	❒	❒
2. Have any dietary restrictions?	❒	❒
3. Ever been hospitalized?	❒	❒
4. Ever had surgery?	❒	❒
5. Have frequent headaches?	❒	❒
6. Ever had a head injury?	❒	❒
7. Have a medical device being brought to camp?	❒	❒
8. Wear glasses, contacts, or protective eyewear?	❒	❒
9. Ever had frequent ear infections?	❒	❒
10. Ever had seizures?	❒	❒
11. Ever have difficulties during exercise?	❒	❒
12. Ever had high blood pressure?	❒	❒
13. Ever been diagnosed with a heart murmur?	❒	❒
14. Have an orthodontic appliance being brought to camp?	❒	❒
15. Have any skin problems (e.g., itching, rash, eczema)?	❒	❒
16. Have diabetes?	❒	❒
17. Have asthma?	❒	❒
18. Ever had an eating-disorder?	❒	❒
19. Have problems with sleep walking?	❒	❒

20. Ever had emotional difficulties? ❒ ❒
21. Anything else not mentioned? ❒ ❒

If you answered "yes" to any questions, please explain below:

____

____

What was the date and outcome of the student's last physical exam? ______________________________

Does the student have any handicapping, chronic, or recurring conditions that requires special care/diet/or facilities? If yes, please specify.

____

____

Does the student have any physical limitations on activity? If yes, please specify.

____

____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

____

____

Healthcare Provider Information:

Family Doctor's Name: ______________________________ Phone: ______________________________

Address: ____

Personal Health/Accident Insurance Carrier: ____

Policy Number: ___________________________ Group Number: ______________________________

I hereby give permission to have my son/daughter receive any emergency medical treatment deemed necessary by Susquehanna University personnel while he/she is participating in the summer program and, intending to be legally bound, I agree to indemnify and hold harmless Susquehanna University, its officers, instructors, and employees from any liability due to any incompleteness or inaccuracies in the information provided in this medical form.

Furthermore, in consideration for my son/daughter being given permission to participate in the summer program, and intending to be legally bound, I agree that Susquehanna University, and its officers, instructors and/or employees shall not be liable for any claims, demands, injuries, death or damages to my son/daughter and/or his/her property arising out of or connected with the summer program. I hereby expressly release and discharge Susquehanna University and its officers, instructors and employees from all such claims, demands, injuries, deaths, and damages.

Date: ___________________________ ______________________________________

Print Parent/Guardian Name

____

Parent/Guardian Signature