



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 prior to arrival. Please fill out this form to the best of your knowledge. Mail completed form 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 who 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 _____

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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 and 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 Degenstein 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 checkout. 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. You must also attach the CDC COVID-19 Vaccination Record Card. 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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have any dietary restrictions?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have a medical device being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever have difficulties during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have any skin problems (e.g., itching, rash, eczema)?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
18. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have problems with sleep walking?	<input type="checkbox"/>	<input type="checkbox"/>

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 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 they are 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 their 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.

Inherent risk of exposure to Covid-19 exists in any public place where people are present. Covid-19 is an extremely contagious disease that can lead to severe injury and death. According to the centers for disease control and prevention, senior citizens and those with underlying conditions are especially vulnerable. By entering the facility and facility grounds, participant voluntarily assumes all risks related to exposure to Covid-19.

Date: _____

Print Parent/Guardian Name

Parent/Guardian Signature