

# Syracuse University Clinic and Camp Health Form - 2012

*A sports camp or clinic participant will not be permitted to attend a camp or clinic unless this form is completed, in its entirety, and returned no later than one week prior to registration. On-site registrants must have a completed form before participation will be permitted. PLEASE PRINT CLEARLY*

**THOSE PARTICIPANTS REQUIRING TAPING OR SPLINTING FOR SPORTS PARTICIPATION MUST SUPPLY THEIR OWN TAPING AND SPLINTING SUPPLIES FOR PRE-EXISTING CONDITIONS.**

Participant's Name:		Gender : (circle one) Male Female	
	Last Name	First Name	
Participant's DOB: / /	Age:	Camp/Clinic:	Session:
Parent/Guardian:		Daytime Phone: ( )	
Evening Phone: ( )		Cell Phone: ( )	
Address:			
	Street Number	City	State ZIP
If not available in an emergency, notify: 1		Number:	
2		Number:	

**\*\*\*\*\*Please include a copy of your insurance card OR complete the following\*\*\*\*\***

Insurance Company:	Policy Holder:
Relation to Camper:	Policy Holder DOB: / /
Policy/Group #:	Insurance Company Phone Number:
Primary Care Physician:	Contact Number: ( )
Pre-approval Required? (circle one) YES NO	

<b><u>Immunization History - Dates are REQUIRED or include a copy of your immunization record.</u></b>	<b><u>General Medical Information -</u></b>
DTP Series:                      Booster:	Asthma: (Circle one) YES NO
Measles:                              Rubella:	Current Medications:
Tetanus:                              TB Test:	Allergies:
Meningitis:                              Hepatitis B:	Food:
Chicken Pox:	Medications:
Haemophilus Influenza Type B:	Bee Stings:                      Other:

**PARTICIPANTS with the following conditions must provide written physician's clearance before attending a Syracuse Camp or Clinic. Please return an official letter of physician's clearance (for each item) with the form. Participants without official physician clearance will be withheld from competition until clearance is received in writing.**

Please specify the condition in the space provided:

Fracture in the last 6 months:	Surgery in the past year:
Seizure disorder:	Heart Condition:
Diabetes:	Hemophilia/blood disorder:
Loss of organ:	Hospitalization in last 6 months:
Spinal, head injury or concussion:	Other Injury/Illness requiring ongoing care:

**PARENT/GUARDIAN AUTHORIZATION and NOTIFICATION:**

*Meningococcal Meningitis* is a bacterial illness affecting the brain. It can be spread by a cough, sneeze, kiss, sharing drinks, or by any other direct contact or airborne means of transportation. Therefore, students/campers residing in small areas, such as dormitories, are at an increased risk for contracting the illness.

The signs and symptoms of Meningococcal Meningitis are similar to the common flu often making it hard to detect. The signs and symptoms include the following: high fever, nausea, vomiting, fatigue, headache, stiff neck/back, skin rashes, and confusion. Frequently, not all signs and symptoms occur, and the illness may progress rapidly. Treatment of Meningococcal Meningitis is antibiotic therapy.

A vaccination is available, and is an effective way to help prevent Meningococcal Meningitis, although any vaccine is not an absolute guarantee. There are rarely side effects associated with this vaccination. **Syracuse University summer camps will not provide the Meningitis vaccine.** Contact your family care provider for information regarding availability and associated costs of the vaccination.

I, the parent of legal guardian have received, reviewed, and understand the above information regarding Meningococcal Meningitis and my son/daughter has either received the immunization within the past 10 years preceding or has elected not to obtain the immunization against Meningococcal Meningitis.

**To the best of my knowledge this health history information is correct and the person herein described has my permission to engage in all camp activities, with the exception of any physical limitations as described. In the event that I cannot be reached in an emergency, I hereby give permission to the medical personnel to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child as named above. I agree to indemnify Syracuse University and its employees for any claim which may hereafter be presented by our (my) son/daughter as a result of any such injuries.**

Signature:	Date:
Witness:	Date:

**\*Please use the cups provided at each drinking station when utilizing the Gatorade/water. No use of personal cups or containers!**