CU-YLI
CLEMSON UNIVERSITY YOUTH LEARNING INSTITUTE

PARTICIPANT HEALTH FORM

(One form to be completed by each participant)

Participant Name

Participant Date of Birth

Participant Sex ☐ Male ☐ Female

IMPORTANT: Please notify the director if the participant is exposed to any communicable diseases during the two (2) weeks prior to arrival.

HEALTH HISTORY (Check all that apply.)

☐ Asthma/Shortness of Breath	☐ Females: Menstrual Issues	☐ Recurrent/Chronic Illness	**Explain each checked item...**
☐ Back/Joint Problems	☐ Glasses or Contacts	☐ Seizures	
☐ Bed Wetting	☐ Headaches	☐ Skin Problems	
☐ Chest Pain	☐ Hospitalized	☐ Surgery	
☐ Diarrhea	☐ Problem Falling Asleep	☐ Past 9 months: Leave Country	
☐ Diabetes	☐ Recent Infectious Disease	☐ Past 12 months: Mononucleosis	
☐ Fainting or Dizziness	☐ Recent Injury	☐ Other	

ALLERGIES & MEDICATIONS

Is the participant allergic to foods?
☐ **YES** ☐ **NO** If yes, list & describe reaction...

Is the participant allergic to medications?
☐ **YES** ☐ **NO** If yes, list & describe reaction...

Is the participant allergic to the environment? (e.g. insect stings, hay fever, etc.)
☐ **YES** ☐ **NO** If yes, list & describe reaction...

Does the participant take medications on a routine basis? (Attach additional pages if necessary)
☐ **YES** ☐ **NO** If yes, describe...

Non-prescription medications may be stocked by the camp/program and are used on an as needed basis to manage illness and injury.
List any non-prescription medications that the participant should **not** be given.

TETANUS BOOSTER

Date of Last Tetanus/Tetanus Booster Dose

IMMUNIZATIONS *18 years and younger*

☐ Participant has been fully immunized with all up to date immunizations required for school.

☐ Participant **has not** been fully immunized.

RESTRICTIONS

List any activities in which the participant **may not** participate.

HEALTH CARE PROVIDERS

☐ Participant has family health insurance. ☐ Participant does **not** have family health insurance.

Primary Care Doctor Name — Phone Number

Dentist Name — Phone Number

INSURANCE

Insurance covers up to a maximum of $3,000.
Program insurance coverage is in effect while the participant is in attendance and while en route to and from headquarters. If the participant returns home sick or injured without seeing a doctor while in attendance, the participant must see a doctor within 24 hours for insurance to pay. Medical costs that exceed the policy amounts will be the responsibility of the participant.

PARTICIPANT AUTHORIZATION & PERMISSION TO TREAT

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me and the examining physician. I hereby give permission to the medical personnel selected by the program director to provide routine health care: to administer medications; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the program director to secure and administer treatment, including hospitalization, for the person named above.

Participant Signature *(18 or older)* — Date

☐ *By checking this box, you acknowledge your electronic signature is the legal equivalent of your manual signature on this form.*

Parent/Guardian Signature — Date — Relationship to Participant

☐ *By checking this box, you acknowledge your electronic signature is the legal equivalent of your manual signature on this form.*