

**ST. LAWRENCE UNIVERSITY  
SUMMER PROGRAMS HEALTH FORM**

Revised 5/07 by Athletic Department

**I. GENERAL INFORMATION**

Program Attending: \_\_\_\_\_ Dates: \_\_\_\_\_

Resident (Living on Campus) \_\_\_\_\_ Commuter (Living at Home) \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_

STREET CITY STATE ZIP CODE  
Parent/Guardian Name \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_

BUSINESS HOME MOBILE  
Emergency Contact \_\_\_\_\_ Phone No. ( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
BUSINESS HOME MOBILE

Health Insurance: \_\_\_\_\_  
NAME OF COMPANY POLICY NUMBER

Family Doctor: \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_  
NAME PHONE

STREET CITY STATE ZIP CODE

**II. HEALTH HISTORY**

Height \_\_\_\_\_ Weight \_\_\_\_\_

| <b>Do you have or have you ever had:</b> | <b>YES</b> | <b>NO</b> |   | <b>YES</b> | <b>NO</b> |
|--|------------|-----------|---|------------|-----------|
| TB or contact with tuberculosis          |            |           | Neurological problems   |            |           |
| Rheumatic fever                          |            |           | Epilepsy  |            |           |
| Eye, ear, nose problems or injuries      |            |           | Fainting spells   |            |           |
| Heart problems                           |            |           | Head injury with unconsciousness  |            |           |
| High blood pressure                      |            |           | Muscle or bone problems or injuries   |            |           |
| Irregular or rapid heart beat            |            |           | Diabetes mellitus   |            |           |
| Chest pain                               |            |           | Emotional or psychiatric problems   |            |           |
| Asthma                                   |            |           | Physical handicap(s)  |            |           |
| Gastrointestinal problems                |            |           | Operations/hospitalizations (list below)  |            |           |
| Kidney problems                          |            |           | Other medical problems (list below)   |            |           |
| Allergies (please list)                  |            |           | Daily medications   |            |           |
| 1.                                       |            |           | <b>IF YES : MEDICATION FORM ON REVERSE<br/>MUST BE COMPLETED BY DR. /PA/RNP</b> |            |           |
| 2.                                       |            |           |   |            |           |
| 3.                                       |            |           |   |            |           |
| 4.                                       |            |           |   |            |           |

Please elaborate on any "YES" answers here:

**III. IMMUNIZATIONS – A COPY OF THE CAMPER’S MOST CURRENT IMMUNIZATION RECORD MUST BE ATTACHED OR FILLED OUT BELOW IN ORDER FOR THE CHILD TO PARTICIPATE IN THIS CAMP**

D/M/Y D/M/Y

|   |  |  |
|---|--|--|
| MMR (Measles, Mumps, Rubella, two immunizations)            |  |  |
| DPT (Diphtheria, Pertussis, Tetanus, date series completed) |  |  |
| TD ( Tetnis, Diphtheria Boosters)                           |  |  |
| <b>Haemophilus influenza type b</b>                         |  |  |
| <b>Hepatitis b</b>  |  |  |
| <b>Varicella (chicken pox)</b>                              |  |  |

**IV. CONSENT**

I \_\_\_\_\_ verify the above information to be true and give permission to the St. Lawrence University Health Service staff to treat my child as they deem appropriate. I also give permission for the release of medical information to the appropriate individual(s); (for example, physician, certified athletic trainer, etc.)

PARENT'S/GUARDIAN SIGNATURE

RELATIONSHIP TO APPLICANT

DATE