

Camper's Name _____

Session(s) # _____

Summer Sport Camp Medical History Questionnaire

INSTRUCTIONS: Circle the appropriate answer. Please elaborate yes answers in the space provided.

- yes no 1. Does your child have any type of allergies to food, medications, or insects?
- yes no 2. Is your child currently being treated for diabetes or been told that she/he has diabetes?
- yes no 3. Has your child ever been told that he/she has a heart murmur?
- yes no 4. Has your child ever been treated for any heart or circulatory system problem?
- yes no 5. Has your child been "knocked out" or experienced a concussion in the last year?
Please give dates and severity of condition. Is there a history of seizures of any kind?
- yes no 6. Are there any long term effects from head injury?
- yes no 7. Does your child wear contact lenses or glasses for athletic participation?
- yes no 8. Has your child had any sprains, strains, fractures, etc. which required medical attention.
- yes no 9. Has your child had any surgeries of any kind in the last year?
- yes no 10. Has your child ever been told that he/she has a hernia?
- yes no 11. Are there any other medical conditions or health problems which should be discussed?
- yes no 12. Is your child currently on any type of medication which will need to be administered while in camp? Explain THOROUGHLY if answer is yes.
- yes no 13. Does your child have any type of allergies to food, medications, or insects?

Please explain "yes" answers also, is there any reason why your son/daughter cannot fully participate in camp?

_____ I understand the above questions and have answered them completely and truthfully to the best of my ability.
 _____ I give permission for any necessary medical attention to be given to my son or daughter in the event that an injury or illness should occur while participating in a summer sports camp at Butler University. I understand that if my child suffers a serious injury which may require advanced medical care he/she may be transported to a local hospital for appropriate care.

Parent or Guardian signature _____

Father's Name (print) _____ Mother's Name (print) _____

Home Phone # _____ Home Phone # _____

Work Phone # _____ Work Phone # _____

Family Doctor _____ Office Phone # _____

Name and phone # of whom should be called in the event that you cannot be reached?
