Student Health and Well-Being
UNIVERSITY OF SOUTH CAROLINA

Summer Camp
HEALTH HISTORY FORM

Form must be filled out before child arrives to camp.
Please be sure all information is complete.

Center for Health and Well-Being
c/o Medical Records
1409 Devine St.
Columbia, SC 29208

Camper's name (Last, First, Middle Initial) _____

Today's Date _____

Camper's mailing address _____ City _____ State _____ ZIP _____

Emergency Contact Name _____ Relationship _____

Parent or guardian's email address _____

Preferred Phone (Cell #) _____

Camper's Date of Birth _____

ALLERGY HISTORY

List any drug allergies: _____ Reaction: _____

List any allergies to materials (such as latex): _____ Reaction: _____

List any food allergies: _____ Reaction: _____

List any allergies to insects/other: _____ Reaction: _____

Are you receiving allergy injections? _____

CURRENT MEDICATIONS
List any drugs, medications, vitamins, and dietary supplements your child currently uses:

_____

_____

PERSONAL HISTORY
Indicate whether your child has had any of the following medical issues:

Y	N	General Medical Health Problems
○	○	Acne
○	○	Anemia
○	○	Anxiety
○	○	Asthma/Lung disease
○	○	Bleeding problem
○	○	Blood clots in legs or lungs
○	○	Broken bones
○	○	Cancer
○	○	Cerebral palsy
○	○	Chicken pox
○	○	Colitis, ulcerative/Crohn's disease
○	○	Concussion
○	○	Congenital defect
○	○	Diabetes
○	○	Epilepsy, seizures
○	○	Hearing loss
○	○	Heart murmur/other heart problems
○	○	Hepatitis
○	○	High blood pressure
○	○	High cholesterol
○	○	Irritable bowel
○	○	Kidney infection, stones
○	○	Migraine headaches
○	○	Mononucleosis
○	○	Pneumonia
○	○	Rheumatic fever
○	○	Rheumatoid, other arthritis
○	○	Seasonal allergies
○	○	Scoliosis
○	○	Sickle cell
○	○	Thyroid problems
○	○	Tuberculosis or positive PPD
○	○	Ulcers
○	○	Depression
○	○	Other mental health_____

If yes to any of the above, please explain:

_____

FAMILY HISTORY
Has any family member in the last two generations (siblings, parents, grandparents) had any of the following?
If yes, who and when?

Y	N	Has a family member had?	Who?
O	O	Blood clots in legs, lungs	_____
O	O	Cancer	_____
O	O	Depression	_____
O	O	Diabetes	_____
O	O	Genetic Disorder	_____
			_____

Y	N	Has a family member had?	Who?
O	O	Heart disease High	_____
O	O	blood pressure	_____
O	O	Liver disease	_____
O	O	Stroke, blood vessel disease	_____
O	O	Other: _____	_____

IMMUNIZATIONS
I certify that my child is or is not compliant with the below immunizations:

Y	N		Y	N	
O	O	Hep B	O	O	Menactra
O	O	Measles	O	O	Menveo
O	O	Mumps			
O	O	Rubella			
O	O	Varicella			
O	O	TDap			

SURGICAL HISTORY
List all prior operations with dates (i.e. appendectomy, pinning of fracture):

_____
_____
_____

HOSPITALIZATIONS
List any hospitalizations not included in surgical history (i.e. overnight stay):

_____
_____
_____

ADDITIONAL INFORMATION
Is there anything about your childs physical, mental or emotional health that would be helpful to Student Health Services (SHS)in providing medical care?

_____
_____

READ, CHECK AND SIGN BELOW.

- O As a parent or legal guardian, I am aware that Student Health and Well-Being (SHWB) services will be provided on a fee for service basis. I accept personal responsibility for the payment of incurred charges at the time services are rendered.
- O As a parent or legal guardian, I understand that I am responsible for filing outpatient charges with my health insurance carrier and acknowledge that my responsibility to the University is unaffected by the existence of health insurance coverage.
- O As a parent or legal guardian, I authorize any medical treatment for my child that may be advised or recommended by the medical providers at SHWB**.**
- O As a parent or legal guardian, I have personally supplied the above information and attest that it is true and complete to the best of my knowledge. As a parent or legal guardian, I understand that the information contained on this form and in my child's medical records is strictly confidential and will not be released to anyone without my written authorization unless required by law. If my child should be ill or injured or I am otherwise unable to sign the appropriate medical release form, I give my permission to SHWB to release information from my child's medical record to a phsician, hospital, or other medical professional involved in providing me with emergency treatment and/or medical care.
- O **Permission to Treat:** I hereby authorize any medical treatment for my child that may be advised or recommended by the health care providers at SHWB at USC. I am aware that the practices of medicine are not an exact science and I understand that no guarantees have been made to me about the results of treatments, examinations, procedures, or analysis.
- O **Acknowledgment of Receipt of Notice of Privacy Practice:** I attest that this office has given me a copy of its Notice of Privacy Practices to review.
- O By signing the acknowledgment below, you are indicating that you have read and understand the above information.

_____

Signature of parent or legal guardian Date

_____

Signature of reviewing medical provider Date