MEDICAL HISTORY

**STUDENT NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CAMPER’S NAME: DATE OF BIRTH: / /**

**PERSON FILLING OUT FORM: TODAY’S DATE: / /**

Review the list below and check “Yes” or “None” for each. For any checked “Yes”, please provide details including diagnosis, treatment and dates (use a separate sheet if necessary).

|  |  |  |  |
| --- | --- | --- | --- |
|  | * **YES**
 | * **NONE**
 | **DETAILS (if checked YES)** |
| **Current Health Issues** |  |  |  |
| **“Med-Alert” Condition** |  |  |  |
| **Current Medications** |  |  |  |
| **Current Supplements** |  |  |  |
| **Allergies to Medications** |  |  |  |
| **Other Allergies** |  |  |  |
| **Prescription for EpiPen** (if “Yes”, EpiPen form must be completed by physician and returned) |  |  |  |
| **Childhood Illness** (whooping cough, chicken pox, rheumatic fever, etc.) |  |  |  |
| **Neurological Problems** (headaches, migraines, seizures, head injury, paralysis, etc.) |  |  |  |
| **Ear, Nose, Throat Problems** (ear infections, hearing loss, sinusitis, tonsillitis, dental issues, etc.) |  |  |  |
| **Heart Problems** (palpitations, dizziness, fainting, arrhythmia, high/ low blood pressure etc.) |  |  |  |

pg. 1

**CAMPER’S NAME:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | * **YES**
 | * **NONE**
 | **DETAILS (if checked YES)** |
| **Musculoskeletal Problems** (broken bones, dislocation, scoliosis, weakness, etc.) |  |  |  |
| **Gastrointestinal Problems** (abdominal pain, diarrhea, constipation, celiac disease, significant weight gain/loss, etc.) |  |  |  |
| **Metabolic Problems**(diabetes, thyroid, etc.) |  |  |  |
| **Genital/Urinary Problems** (urinary tract infections, kidney stones, menstrual problems, etc.) |  |  |  |
| **Skin Problems** (rash, eczema, etc.) |  |  |  |
| **Past Surgeries, Past Hospitalizations or Other Serious Illness** |  |  |  |
| **Physical Limitations** |  |  |  |
| **Any Heath Concerns that require assistance while on campus** |  |  |  |
| **Psychological Problems** (include any current and past diagnoses: Depression, Anxiety, Mood Disorder, ADHD, Eating Disorder, etc.) |  |  |  |
| **Current Psychological Treatment** (include individual therapy, group counseling, psychiatric treatment, etc.) |  |  |  |
| **Past Psychological Treatment History** (include age at time of treatment) |  |  |  |
| **Past Hospitalizations for Mental Health** (include dates of hospitalizations) |  |  |  |

pg. 2

**CAMPER’S NAME:**

**IMPORTANT:** The College’s counseling staff is not available in the summer during Curiosity Camp. We assume Curiosity Campers will be self-sufficient when it comes to mental health issues. Students should not expect our Campus Life staff or our Wellness Center nurse to provide mental health counseling. We also assume that campers will be in charge of self-administering any over the counter or prescription medications they may be required to take during their time at camp.