Session 1 ______
Session 2 ______
Summer Day 1 ____
Summer Day 2 _____
Spring Break _____

Participant's Name ________________________

DUKE SUMMER HEALTH FORM

This form must be completed and signed by the participant's legal guardian. The information we ask you to provide is necessary in the event your child needs medical treatment while camp is in session. **This form will be returned to you if it is incomplete**. Please type or print in **black ink.**

PARTICIPANT INFORMATION

Participant's Name ____
Permanent Address ____ Date of Birth __________ Sex ___
City/State/Zip ____ Home Phone _________________

MEDICAL EMERGENCY CONTACT INFORMATION

Person to contact first:
Name ____________________________________
Relation __________________________________
Daytime Phone _____________________________
Evening Phone______________________________

Backup contact (relative or friend):
Name ____
Relation ____
Daytime Phone______________________________________
Evening Phone______________________________________

INSURANCE POLICY INFORMATION

The above-named child is covered by health insurance: Yes No
If yes, provide the following information which is required by Duke University Medical Center to expedite treatment and to facilitate the billing process.

Policy Holder's (P.H.) Name____ P.H.'s Date of Birth ___________
Address ____ Relation____________________
City/State/Zip ____ Occupation __________________
P.H.'s Employer ____
Employer's Address ____
Insurance Company____
Insurance Company's Address ____
Policy # ____ Plan # ______________________

MEDICAL TREATMENT CONSENT

I, the legal guardian of the above-named camper, authorize the Duke Summer Program staff to seek medical treatment for the camper as they see necessary at Duke University Medical Center or another nearby facility. I consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care subsequently deemed necessary by a licensed health care provider during the participant's session. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, and that it is given to provide the program staff authority to seek medical treatment, and to provide a licensed health care provider the authority to administer this treatment as s/he judges necessary to the above-named child. I accept responsibility for payment of all services rendered; I authorize any medical facility which renders services to release medical information necessary for the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, the Program staff will make a good faith effort to contact me or the above-named person(s) before seeking treatment. If this is not possible, I understand that the Program staff will notify me or my designee as soon a possible of any and all diagnoses and treatments.

______________________________ ______________________________ ______________

Legal Guardian's Signature Print Name Date

Participant's Name ___________________

Directions: Completion of this form by a parent or guardian is required before a student can participate. Please answer all questions. **Incomplete forms will be returned to you for the missing information**. Please type or print in black ink. Attach any specific recommendations from your physician to this form.

DOES THE PARTICIPANT CURRENTLY HAVE ANY OF THE FOLLOWING? (if yes, please describe)

Drug allergies: ______________________________

Food allergies: ______________________________

Allergies to insect bites: ______________________________

Special dietary needs: ______________________________

Asthma: ______________________________

Frequent headaches: ______________________________

Dizziness or seizures: ______________________________

LIST: Other health problems: ______________________________

____

Limitations of Activities: ______________________________

____

Medications the camper is currently taking: ______________________________

____

____

(**Please note:** Our staff cannot administer any medications, prescription or non-prescription to campers. This includes over-the-counter medicines like Advil or Tylenol for minor headaches or pains. If the camper will need to take medications while attending our program, s/he must bring the medication to camp and assume responsibility for taking it as needed or indicated.)

Will your son/daughter require any specific treatment for a medical/emotional condition while participating in our program? If yes, please explain. yes __________no

____

____

MEDICAL HISTORY

IMMUNIZATION DATES:

Measles ____________

Mumps ____________

Rubella ____________

OR MMR____________

Last Tetanus ____________

(DPT, TT or TD)

Polio Series completes ____________

Date of last medical check-up: ____________

Hospitalizations in the past 5 years: Describe

____

____

____

____

____

____

PHYSICIAN'S INFORMATION *(to be completed by physician)* Please **PRINT** the following information:

Physician's Name: ______________________________

Address: ______________________________

City/State/Zip ______________________________

Telephone ______________________________

I have examined the above named participant and found she/he to be able to participate in all activities of the Duke University ______________________ *Summer Program.*

______________________ ______________________ ____________

Physician's Signature Print Name Date