



FSU iCamp Medical History Form

The purpose of this form is to provide camp staff with information regarding your child's/participant's current health status. This form is required for treatment if the participant should become ill or injured while involved in a FSU iCamp program.

GENERAL INFORMATION

Name of participant	Age	Date of birth	Gender
Home street address (city, state, and zip code)			
Physician's name			Phone number

EMERGENCY CONTACT INFORMATION

Emergency contact 1	Relationship	Home phone #	Cell phone #
Emergency contact 2	Relationship	Home phone #	Cell phone #

ALLERGIES

Please list all allergies to medications, food, insect bites/stings, animals, plants, other, etc. Include the type of reaction and severity and recommended treatment. Please use additional pages if necessary.

Allergy	Reaction/severity	Recommended treatment

1. Does the participant suffer from Anaphylaxis? Yes No
**Anaphylaxis is a severe allergic reaction marked by swelling of the throat, hives, and trouble breathing*
2. Does the participant require an EpiPen? Yes No
3. Does the participant require an inhaler? Yes No

NUTRITION

Does the participant have any special dietary requirements or a regimen to be followed? Yes No
 If yes, please explain:

IMMUNIZATIONS

Provide a copy of the participant's shot records from their school.

MEDICAL CONDITIONS

List any medications the participant currently takes. Include the dosage schedule and any specific instructions for use. Also, please indicate (yes/no) if the minor participant is allowed to take their medication on their own or if it should be monitored by camp personnel. This also includes any type of birth control.

Medication	Purpose	Dose schedule	Instructions	Self-medicate (yes/no)

**Be sure to bring enough medication in sufficient quantities and in the original containers labeled with the participant’s name and doctor’s contact information. Make sure they are not expired, including inhalers and EpiPens.*

OVER-THE-COUNTER MEDICATIONS

Does the participant have permission to take over-the-counter medication in case of an accident, illness or injury? The camp is not responsible for providing any over-the-counter medications. Please check all the participant has the permission to take:

<input type="checkbox"/> Tylenol/Acetaminophen	<input type="checkbox"/> Tums/Antacid	Special considerations or notes regarding over-the-counter medications:
<input type="checkbox"/> Ibuprofen (pain/swelling)	<input type="checkbox"/> Immodium/anti-diarrhea	
<input type="checkbox"/> Benadryl/Antihistamine	<input type="checkbox"/> Antibacterial gel/lotion	
<input type="checkbox"/> Robitussin/Expectorant	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Sudafed/Decongestant	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Pepto Bismol	<input type="checkbox"/> Skin Ointments (in case of rash, antibacterial, athlete’s foot, etc.)	

HEALTH INSURANCE INFORMATION

Providing the information does not guarantee payment of your claim by your insurance company. You are responsible for any charges for services rendered. Any emergency health care needed will run through Thagard Health Center at FSU and will be billed from there.

Please attach a copy of the front and back of your insurance card.

Policy holder’s name	Name of insurance carrier
Policy #	Group #
Insurance company address	Telephone number

Health Information Privacy Statement and Authorization

The FSU iCamp Medical History Form is for health care concerns for minors attending an FSU sponsored camp/activity. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. Minimal necessary information may be shared with program staff to provide adequate safety and health care. Access to this information will be limited, but copies may be requested by the camp sponsor, by the participant or their legal representative. In the case of illness, injury, or emergency, I understand that efforts will be made to contact the individual listed as the emergency contact by camp personnel. Medical providers are authorized to disclose protected health information to the adult in charge, camp management and/or to any health care provider involved in provide care to my participant. I have read the above procedures for handling the health and medical information and agree to the release of any records necessary for treatment, referral, billing, insurance purposes and ongoing care.

I attest that the information I have provided in the FSU iCamp Medical History Form is complete and accurate. I am aware and accept the risks inherent in program activities and my participant has permission to engage in all prescribed activities, except noted by me.

_____ (participant’s name) has my permission to receive medical attention in the event of illness, injury or medical emergency while participating in the FSU iCamp program. I will assume financial responsibility for any cost of health care for my participant that may occur during this camp. I agree to hold harmless, defend, and indemnify the FSU Board of Trustees, FSU their officers, agents, and employees from any and all liability, loss, damages, costs, or expenses which are sustained, incurred or required arising out of the actions of my participant in the course of the event/camp.

Signature of Parent/Guardian: _____ Date: _____

Name of Parent/Guardian (printed): _____