Youngstown State University

Health History Form

The information on this form is not part of the participant acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to the information on this form should be provided to the program/activity coordinator upon the participant's arrival at YSU. Please provide complete information so that the YSU staff can be aware of your needs.

Bring this Health History Form with you on the first day, or turn in before as requested by the program/activity coordinator. In case things change, such as allergies or medication, please contact us immediately so we are aware of those changes and can make the amendments to our records.

Name _____ Date of Birth _____
Last First Middle

Custodial Parent/Guardian _____ Cell Phone _____

Address _____ Home Phone _____
Street Address City State Zip Code

Business Address _____ Work Phone _____
Street Address City State Zip Code

Email Address _____ Second Email Address _____

Second Parent/Guardian or Emergency Contact _____

Address _____ Cell Phone _____
Street Address City State Zip Code

Business Address _____ Work Phone _____
Street Address City State Zip Code

If not available in an emergency, notify _____

Relationship _____ Cell Phone _____

Address _____
Street Address City State Zip Code

Insurance Information

Is the participant covered by family medical/hospital insurance? ◯ Yes ◯ No

If so, indicate the carrier or plan name _____ Group # _____

Carrier Address _____

Name of Insured _____ Relationship to participant _____

Number of policy/holder or insurance ID number _____

IMPORTANT - These boxes must be completed for attendance*

Parent/Guardian Authorization: The health history is correct and complete as far as I know, for the person herein described has permission to engage in all activities except as noted. I hereby give permission to Youngstown State University to provide first aid, administer prescribed medications, and seek emergency medical treatment if necessary. I agree to the release of any records necessary for insurance purposes. I give permission to Youngstown State University to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the university to secure and administer treatment, including hospitalization, for the person named above. I also understand that any and all expenses incurred by a medical emergency will be covered by myself and/or my insurance carrier, and will not be covered by Youngstown State University.

Signature of parent/guardian _____

Print Name _____ **Date** _____

I also understand and agree to abide by any restrictions placed on my child(ren)s participation in program activities.

Signature of parent/guardian or adult staff member _____

ALLERGIES (List all known) Describe reaction and management for the reaction.

Medication Allergies (list)

_____ _____

_____ _____

Food Allergies (list)

_____ _____

_____ _____

Other Allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.

_____ _____

_____ _____

MEDICATION BEING TAKEN

Please list all medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last t he entire time at YSU. Keep it in the original package/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. The Participant Medication Form is also required if taking medicaiton.

◯ This person **takes medication** as follows: **-OR-** ◯ This person **takes NO medication(s)** on a routine basis.

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications.

Identify any medications taken during the school year the participant does/may not take during the summer: _____

_____

DOCTOR'S INFORMATION

Name of Family Physician _____ Phone _____

Address _____

Name of Dentist/Orthodontist _____ Phone _____

Address _____

Hospital Preferred _____ City _____

RESTRICTIONS (the following restrictions apply to this individual)

Does not eat ☐ Red meat ☐ Pork ☐ Dairy products ☐ Poultry ☐ Seafood ☐ Eggs

Other _____

Physical Activity Restrictions (e.g. what cannot be done, what adaptations or limitations are necessary)

_____

_____

Particpant Name: _____

GENERAL QUESTIONS (Explain "yes" answers below)
Has/does the participant:

		Yes	No
1.	Had a recent injury, illness or infectious disease?	◯	◯
2.	Have a chronic or recurring illness/condition?	◯	◯
3.	Ever been hospitalized?	◯	◯
4.	Ever had surgery?	◯	◯
5.	Have frequent headaches?	◯	◯
6.	Ever had a head injury?	◯	◯
7.	Ever been knocked unconscious?	◯	◯
8.	Wear glasses, contacts, or protective eyewear?	◯	◯
9.	Ever had frequent ear infections or have ear tubes?	◯	◯
10.	Ever passed out during or after exercise?	◯	◯
11.	Ever been dizzy during or after exercise?	◯	◯
12.	Ever had seizures?	◯	◯
13.	Ever had chest pains during or after exercise?	◯	◯
14.	Ever had high blood pressure?	◯	◯
15.	Ever been diagnosed with a heart murmur?	◯	◯
16.	Ever had back problems?	◯	◯

		Yes	No
17.	Have an orthodontic appliance being brought to camp?	◯	◯
18.	Have skin problems (e.g., itching, rash, acne)?	◯	◯
19.	Have diabetes?	◯	◯
20.	Have asthma or other breathing disorders?	◯	◯
21.	Had mononucleosis in the past 12 months?	◯	◯
22.	Had problems with diarrhea/constipation?	◯	◯
23.	Ever had an eating disorder?	◯	◯
24.	Does the participant have Epilepsy?	◯	◯
25.	*Females:* Does participant have a menstrual history?	◯	◯
26.	Ever been treated for ADD, ADHD or Asperger's Syndrome?	◯	◯
27.	Ever had problems with joints (e.g., knees, ankles)?	◯	◯
28.	Ever had emotional difficulties for which professional help was sought?	◯	◯
29.	Has the participant had a routine physical examination in the past twelve months?	◯	◯

Please explain any "yes" answers, noting the question number:

_____

_____

_____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

_____

_____

_____

Immunization Records

By signing below, you are indicating that your child's immunizations are complete and up to date with Ohio Revised Code 3313.67 and 3313.671 for School Attendance.

Date of last tetanus shot _____

_____Date_____
Parent/Guardian Signature

Immunization Refusal

By signing below, you are indicating that your child does not have any immunizations or other medical records for religious or other reasons. You also understand and accept the risks to your child from not being fully immunized.

_____Date_____
Parent/Guardian Signature