MEDICAL AND IMMUNIZATION HISTORY

PLEASE PRINT CLEARLY

PARTICIPANT INFORMATION

PARTICIPANT NAME (FULL): _____ DATE OF BIRTH: _____

SEX ASSIGNED AT BIRTH: ☐ Male ☐ Female GENDER IDENTITY (please share as needed): _____

ADDRESS: _____

EMERGENCY CONTACT INFORMATION

PRIMARY EMERGENCY CONTACT NAME (and one alternate)	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____

INSURANCE INFORMATION

INSURANCE COMPANY: _____ COMPANY PHONE NUMBER: _____

POLICY HOLDER: _____ POLICY NUMBER: _____ GROUP NUMBER: _____

MEDICAL CONSENT

I understand and agree that Davidson College staff may not have medical personnel available at the location of the July Experience Program or off-site program event. In the event of any medical emergency, I authorize and consent to any x-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment, and hospital care that Davidson College's personnel deem necessary for my minor child's safety and protection. I understand and agree that Davidson College staff assume no responsibility for any injury or damage which might arise out of or in connection with such authorized emergency medical treatment. I understand and agree that Davidson College staff may disclose to medical personnel information contained in my minor child's Report of Medical and Immunization History for purposes of medical treatment.

PARENT/GUARDIAN SIGNATURE

FULL NAME (PRINT) _____

SIGNATURE: _____ DATE: _____

(Please complete the medical and immunization history on following pages)

Name:_____

MEDICAL HISTORY

List any medical condition for which you are currently being treated. ☐ Check here if no current conditions.

List any operations or hospitalizations you have had. ☐ Check here if no operations or hospitalizations

Check all applicable items, whether current or past problem. Please provide details in the space provided below.

____ High blood pressure
____ Pain/pressure in chest
____ Rheumatic Fever
____ Asthma
____ Pneumonia
____ Chronic cough
____ Dizziness/fainting spells
____ Migraine headaches
____ Severe head injury/concussion
____ Hearing loss/defects
____ Vision problems
____ Back or neck injury
____ Broken bones
____ Autoimmune disorder (specify)
____ Paralysis
____ Orthopedic issues
____ Arthritis
____ Alcohol/drug problem
____ Depression
____ Anxiety
____ Self-injurious behavior
____ Obsessive compulsive behavior
____ Seizure disorder/epilepsy
____ Eating disorder (specify)
____ Sleep problems
____ Skin disease
____ Anemia/low iron
____ Blood Transfusion
____ Diabetes
____ Gall stones
____ Hepatitis (specify)
____ Intestinal trouble
____ Ulcer
____ Hernia
____ Bladder infection
____ Kidney stone(s)
____ Mononucleosis
____ Chickenpox
____ Other

Please expand on any items checked above – use a separate sheet if needed.

Name:_____

DIETARY/PHYSICAL RESTRICTIONS/ALLERGIES

List any dietary restrictions: ☐ Check here if no dietary restrictions.

List any restrictions to physical activity: ☐ Check here if no physical restrictions.

List any allergies and reaction seen: ☐ Check here if no allergies.

MEDICATION

List all medications you are now taking (include over the counter, supplements, birth control pills, allergy serum, psychotropics).

☐ Check here if no current medications

July Experience Medication Policy: July Experience requires any medications brought to the program by a participant be in their original, labeled, and unaltered bottle. Participants may bring the exact dosage needed for the program, plus one or two extra doses. Over the counter medication must also be in original packaging. Participants are responsible for finding a secure and discreet location and maintaining the security of his or her medication for the duration of the program. All medications must be listed on this form.

**Does the student have parental permission to self-administer medication(s)?* ☐ Yes ☐ No

PARENT/GUARDIAN INITIALS: _____

Name:_____

IMMUNIZATION HISTORY & TUBERCULOSIS SCREENING

Information on immunizations may be provided using one of the following two methods:

1. This form completed by a healthcare provider and signed
2. A print out of all immunizations from a physician's office signed or from a clinic with the clinic stamp
3. **ALL students must complete the Tuberculosis Risk Assessment Quiz located on the student portal.**

PARTICIPANT INFORMATION

PARTICIPANT NAME (FULL): _____ DATE OF BIRTH: _____

SEX ASSIGNED AT BIRTH: Male Female

ADDRESS: _____

DATES OF IMMUNIZATIONS

☐ Check here if this information is included in attachment

DPT _____ Booster_____ Booster _____

Polio OPV (Sabin) _____ Booster_____ Booster _____

MMR (Measles, Mumps, Rubella) _____ Booster _____

Tdap _____Booster (required within 10 years)_____

Tuberculin Test_____

Hepatitis B _____

Varicella (chicken pox) _____

Other_____

Blood Type _____

BCG (Bacillus Calmette-Guerin) _____

PRIMARY HEALTH CARE PROVIDER

Full Name (printed): _____ Phone: _____

Signature: _____ Date: _____

Address: _____