

Ferris State University Athletic Camp Participant Health Form

THIS FORM MUST BE COMPLETED AND SIGNED BY BOTH LEGAL PARENTS/GUARDIANS AND RETURNED BEFORE PARTICIPATION WILL BE ALLOWED. FERRIS STATE UNIVERSITY ("FSU") RESERVES THE RIGHT TO DETERMINE THE EXTENT OF PARTICIPATION OF EACH CAMP PARTICIPANT ("CAMPER") IN ALL ACTIVITIES CONDUCTED BY FSU. THE INFORMATION WILL ALSO BE USED IN THE EVENT OF ANY CAMPER INJURIES/ILLNESS.

CAMPER INFORMATION

PLEASE PRINT

Camp Attending:	Dates of Camp: -
Camper's Name:	Camper's Date of Birth:
Camper's Address:	Home Phone #:
Legal Parent/Guardian:	Legal Parent/Guardian Work Phone #:
Legal Parent/Guardian:	Legal Parent/Guardian Mobile Phone #:

EMERGENCY CONTACT INFORMATION (available 24 hours)

Name:	Relationship:	Phone:
Address:		Additional Phone:

INSURANCE INFORMATION

Primary Insurance Company:		
Policy Holder's Name:	Relationship to Camper:	
Policy #:	Group #:	Insurance Company Phone #:
Pre-approval required? YES NO		Pre-approval Phone #:
Primary Care Physician:		Primary Care Physician Phone #:
Primary Care Physician Address:		
Secondary Insurance Company (if applicable):		
Policy Holder Name:	Relationship to Camper:	
Pre-approval required? YES NO		Pre-approval Phone #:
Policy #:	Group #:	Insurance Company Phone #:

HEALTH HISTORY (to be completed by legal parent/guardian)

History	Allergies	Tetanus Date:
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bee stings	<input type="checkbox"/> Other medical conditions:
<input type="checkbox"/> Bleeding ulcers	<input type="checkbox"/> Hay fever	
<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> Food:	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Medications:	
<input type="checkbox"/> Loss of organ	<input type="checkbox"/> Other:	
<input type="checkbox"/> Other		Date of Last Physical:

Current medications the Camper is taking (medications that are required by Campers should accompany them at camp):

Has the Camper been exposed to any communicable disease or injured in the past three weeks? YES NO

If yes, please explain:

Is the Camper being treated by a physician for any injury or illness? YES NO

If yes, please explain:

Does the Camper have, or had, the following condition(s):

- | | | |
|---|---|--|
| <input type="checkbox"/> Fracture in past 6 months | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Spinal or head injury |
| <input type="checkbox"/> Surgery in past year | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Hospitalization in past 6 months | <input type="checkbox"/> Loss of organ | <input type="checkbox"/> Heart condition |

Type of illness, injury or surgery	Name, city, state of hospital	Date	Current Status

List any other health or personal concerns that FSU should be aware of in regard to the Camper, or Camper's immediate family. Include any physical conditions that might limit or prevent participation in certain physical activities. Describe such conditions and limitations on activities:

I/We declare that my/our answers and statements are correctly recorded, complete and true to the best of my/our knowledge and belief.

Date	Signature of Legal Parent/Guardian	Signature of Legal Parent/Guardian
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