UM Summer Camp Health Questionnaire
(To be filled out by Participant's Parent or Guardian)

Participant_____ **Birthdate**_____/_____/_____ **Sex:** M F

Address_____ **Phone** ( )_____-_____

Family Physician_____ __ _____**Phone**( )_____-_____

Parent/Guardian_____**CampType**_____

Medications: (indicate medication(s) which is/are taken on a regular basis:
Medication Name _____ Dosage_____Directions_____
Medication Name _____ Dosage_____Directions_____

Explain any "yes" answers below:

Nervous System:	**Yes**	**No**
Has the participant ever...		
1. had a head injury?.....	❑	❑
2. been knocked out or unconscious?.....	❑	❑
3. had a seizure?.....	❑	❑
4. had a stinger, burner or pinched nerve?.....	❑	❑
5. had any problems with his/her eyes or vision?.....	❑	❑
6. worn glasses, contacts or protective eyewear?.....	❑	❑
Circulation: Has the participant ever…		
7. been dizzy or passed out during or after exercise?.....	❑	❑
8. had chest pain during or after exercise?.....	❑	❑
9. tired out more quickly than their friends during exercise?.....	❑	❑
10. been told he/she has a heart murmur?.....	❑	❑
11. had racing heart or skipped heartbeats?.....	❑	❑
12. had anyone in their family died of heart problems or sudden death before age 50?.....	❑	❑
Respiratory:		
13. Does the participant ever have trouble breathing or cough during or after exercise?.....	❑	❑
Musculoskeletal:		
14. Does he/she frequently have heat or muscle cramps?.....	❑	❑
15. Does he/she use any special equipment (pads, braces, neck rolls, mouth guards, etc.)?.....	❑	❑
16. Has she/he had any injuries of any bones or joints?.....	❑	❑
❑ Head ❑ Neck ❑ Chest ❑Back ❑ Shoulder ❑Elbow ❑Forearm ❑Wrist ❑Hand ❑ Hip ❑ Thigh ❑ Knee ❑ Calf ❑Ankle ❑ Foot		
17. **Skin:** Does she/he have any skin problems (itching, rashes, acne, etc.)?.....	❑	❑
General:		
18. Has he/she ever had surgery or been hospitalized?.....	❑	❑
19. Has he/she had any other medical problems (infectious mono, diabetes, high blood pressure, etc.)?.....	❑	❑
20. Is he/she taking any medications or pills?.....	❑	❑
21. Does he/she have any allergies (medicines, bees or other stinging insects)?.....	❑	❑

22. When was the participant's last tetanus shot?_____
23. When was the participant's last measles immunization?_____

Females only:
24. When was the participant's first menstrual period?_____
25. When was the participant's last menstrual period?_____
26.What was the longest time between the participant's periods last year?_____

Explain "Yes"answers:

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.
Signature of Participant_____ **Date**_____/_____/_____

Signature of parent/guardian _____

Physical Examination
(To be filled out by Child's Doctor)

Date_____/_____/_____

Name of Participant _____ **Age**_____
Birthdate_____/_____/_____

Height_____ **Weight**_____ **BP**_____/_____ **Pulse**_____

Vision: R 20/_____ **L 20/**_____ **Corrected: Y N**

	Normal	Abnorm	Comments	Initials
Heart				
Lung				
Ears				
Mouth				
Musculoskeletal				
Neck				
Shoulder				
Elbow				
Wrist				
Hand				
Back				
Hip				
Knee				
Ankle				
Foot				

Clearance: (circle one)

A. Cleared

B. Cleared after completing evaluation / rehabilitation for:_____

C. Not cleared for: **Collision**

Contact

Noncontact: Strenuous Moderately strenuous Nonstrenous

Due to:_____

Recommendation:_____

_____

Signature of physician_____ **Date**_____/_____/_____

Physician Address_____

Physician Phone_____