NON SCHOLAE SED
VITAE DISCIMVS

TVSCVLVM MICHIGANIENSE
JULY 2018

PARTICIPANT HEALTH FORM

Tusculum Michiganiense will include a variety of outdoor recreation activities. While the activities will be suitable for a high school-aged student of average health, applicants should be aware of the following:

For the safety of all participants, it is very important that the following information be provided in full.

***LEGAL GUARDIAN:** Please check YES or NO for each item. Each question must be answered and please **provide date and details for all YES answers**.

_____

Student's Full Name

_____

Height Weight Sex Date of Birth

General Medical History

Does the applicant currently have or have a history of:

1. Respiratory problems? Asthma? YES NO
   Is the asthma well controlled with an inhaler? YES NO
   If so, please have the student bring inhaler(s) with them for the Camp.
   What triggers an attack? Last episode? Ever hospitalized?_____
   _____
2. Gastrointestinal disturbances? YES NO
3. Diabetes? YES NO
   Specific comments: _____
   _____
   _____
4. Bleeding, DVT (deep vein thrombosis) or blood disorders? YES NO
5. Hepatitis or other liver disease? YES NO
   Specific comments: _____
   _____
   _____

6. Neurological problems? Epilepsy? YES NO
7. Seizures? YES NO
8. Dizziness or fainting episodes? YES NO
9. Migraines? Medications, frequency, are they debilitating? YES NO
   For 6-9. Describe frequency, date of last episode, and severity. _____
   _____
   _____
10. Disorders of the urinary or reproductive tract? YES NO
11. Any disease? YES NO
12. Does this person see a medical or physical specialist of any kind? YES NO
    If "yes" please specify the issue(s) and provide name/address of specialist _____
    _____

Questions 13 and 14 Are For Female Students Only:

13. Treatment or medication for menstrual cramps? YES NO
14. Is she pregnant? YES NO
    Specific comments: _____
    _____
    _____
15. Hypertension? YES NO
16. Cardiac problems? Unexplained chest pain? YES NO
    Specific comments: _____
    _____
    _____

Cardiac Screening:

*** A stress ECG is required if the applicant has any history whatsoever of a heart condition.**
Please provide a written note from your doctor stating the date of the stress ECG and the results.

Heat

17. History of heat stroke or other heat related illness? YES NO
    Specific comments: _____
    _____

Personal History (Counseling/Psychiatric/Learning Disabilities)
We require that any participant with a counseling history demanding medication, hospitalization or residential treatment, display one year of stability before they will be accepted for a summer program.

18. Does the applicant have any physical, cognitive, sensory or emotional condition that would require a special teaching environment? YES NO
    If yes, please describe how the condition affects you _____
    _____
19. Has he/she had treatment, counseling or hospitalization with a mental health professional? YES NO
20. Is he/she currently in treatment or counseling? YES NO
21. Reasons for treatment or counseling?
    - □ Suicide
    - □ Substance abuse/chemical dependency
    - □ Eating disorder (anorexia/bulimia)
    - □ Academic/career
    - □ ADD/ADHD
    - □ Family issues/divorce
    - □ Depression
    - □ Other _____

Please provide **specific dates** and details of counseling Hx and medications that were prescribed:

_____
_____

27. Name and telephone number of therapist?
_____ (_____) _____
Name Phone

Allergies

28. Is he/she allergic to any foods? YES NO
Describe: _____

29. Are there any dietary restrictions? YES NO
Please specify. □ Vegetarian □ Vegan □ Other: _____

30. Allergic to insect bites or bee stings? YES NO
If appropriate please bring 2-3 Epi Pens or Twinjects.
Specific comments: _____
_____

31. Any other allergies? YES NO
Specific comments: _____
_____

Medications

33. Is he/she allergic to any medications? YES NO
If yes, please list: _____
_____
_____

34. Does this person plan to take prescription/non-prescription medications during the camp? YES NO

The student must understand the use of any prescription medications they may be taking. Written specific instructions are necessary. All Students who are required by their personal physician, psychiatrist or health care provider to take prescription medications on a regular basis must be able to do so on their own and without additional supervision.

Medication Dosage Side Effects/Restrictions Prescribed by? For what condition?
_____
_____

If medication or condition changes prior to the start of camp, please inform WCC.

37. Is this person overweight? Underweight? If so, how much? _____ YES NO

39. Is there any other relevant medical information that we should know?
If yes, please explain:_____
_____
_____

40. **Physical Examination**

Date of Last General Exam:_____ Physician Name: _____

41. We require proof of a tetanus shot within 10 years prior to the start date of the program or a waiver form. Waiver forms are available from the Admissions Office upon request.

Date of last tetanus immunization: _____

By my signature, I attest that the information in this form is complete and correct. I believe the student named on page one of this form is medically capable to participate in the *Tusculum Michiganiense* program based on the program information provided on page 1 of this form and in the program brochure.

_____

Legal Guardian's Printed Name | Relationship to student

_____ _____ | (_____)_____

Legal Guardian's Signature | Telephone Number

_____

Student's Signature

For TUSCULUM Office Use Only	☐ Initial Review OK	☐ Detailed Review OK
☐ Check Further	Date _____/_____/_____	Initials _____