



Tusculum Michiganiense MMXIX

CAESAR NON SVPRA GRAMMATICOS

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

Gender

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 ADD/ADHD
 Substance abuse/chemical dependency Family issues/divorce
 Eating disorder (anorexia/bulimia) Depression
 Academic/career Other _____

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

22. Name and telephone number of therapist?

Name

(_____) _____
Phone

Allergies

23. Is he/she allergic to any foods? YES NO

Describe: _____

24. Are there any dietary restrictions? YES NO

Please specify. Vegetarian Vegan Other: _____

25. Allergic to insect bites or bee stings? YES NO

If appropriate please bring 2-3 Epi Pens or Twinjects.

Specific comments: _____

26. Any other allergies? YES NO

Specific comments: _____

Medications

27. Is he/she allergic to any medications? YES NO

If yes, please list: _____

28. 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?
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If medication or condition changes prior to the start of camp, please inform Tusculum.

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

30. Is there any other relevant medical information that we should know?

If yes, please explain: _____

31. Physical Examination

Date of Last General Exam: _____ Physician Name: _____

32. 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 one 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 _____