ARKANSAS TECH UNIVERSITY SUMMER CAMP
HEALTH RECORD

Please Print

Name ______________________ Parent or Guardian ______________________

Parent's Address ______________________ Phone ______________________
Street

____
City State Zip

Name and phone number of another party who may be contacted in case of emergency:

Name ______________________ Phone ______________________

Check below the diseases you have had:

______ Measles	______ Pneumonia	______ Asthma	______ Frequent colds
______ Mumps	______ Appendicitis	______ Hay fever	______ Kidney problems
______ Chicken pox	______ Mononucleosis	______ Sinus headaches	______ Ear trouble

______ Previous Injuries. Nature of Injuries ______________________

Date Injuries Occurred? ______________________

Other Medical Problems or Special Instructions ______________________

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____

Are you ALLERGIC to any medicine? ______________ If so, list: ______________

Other Allergies: ______________________

Blood type, if known ______________ Positive or Negative? ______________

Contact lenses? ______________ Taking daily medicine? ______________ Describe ______________

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I authorize the Arkansas Tech University ______________________ Camp to obtain licensed physicians of their choice for medical treatment and diagnostic procedures deemed necessary in the event of any illness or accident. In the event of an emergency, I give my permission for any procedure the physicians feel are imperative, understanding that every attempt will be made to notify the parent or legal guardian first. (If religious beliefs are held by your family that would complicate medical procedures, please attach a note to this form.) Also, I hereby authorize the Student Health Service at Arkansas Tech University to provide medication and/or treatment as authorized by the consulting physician and deemed appropriate by the Registered Nurse in charge.

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Parent's Signature (This is mandatory) Student's Signature Date

Name of Family Doctor ______________ Town ______________ Phone ______________

I hereby certify that the above named student is physically able to participate in the Arkansas Tech University ______________________ Camp.

______________________ ______________________

Family Physician's Signature or Copy of Camper's Physical Exam (Dated within 12 months of beginning of Camp.) Date