



Summer Institute

# Health History and Examination Form

**Return to:**  
Univ of Delaware  
Attn: Ruth Jackson  
102 A. Lerner Hall  
Newark, DE 19716

## Personal Information

Date of Attendance \_\_\_\_\_

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_  
LAST FIRST INITIAL

Parent or Guardian (or Spouse) \_\_\_\_\_ Home Telephone \_\_\_\_\_

Home Address \_\_\_\_\_

Business Address \_\_\_\_\_ Business Telephone \_\_\_\_\_  
NUMBER AND STREET CITY STATE ZIP

If not available, in an emergency notify:

Name \_\_\_\_\_ Relationship to Participant \_\_\_\_\_

Day Telephone \_\_\_\_\_ Evening Telephone \_\_\_\_\_

## Insurance and Physician Information

Name of Insurance Company \_\_\_\_\_ Policy or Group # \_\_\_\_\_

Is this an HMO?  Yes  No Is this participant covered by Medicaid or any other government plan?  Yes  No

Name of dentist/orthodontist \_\_\_\_\_ Telephone \_\_\_\_\_

Name of family physician (if not examining) \_\_\_\_\_ Telephone \_\_\_\_\_

## Health History

If applicable: give approximate dates; explain below.

### Allergies

### Disease

- |                                 |                                   |                           |                      |
|---------------------------------|-----------------------------------|---------------------------|----------------------|
| _____ Chronic/Recurring Illness | _____ Frequent Ear Infections     | _____ Hay Fever           | _____ Measles        |
| _____ Surgery                   | _____ Heart Defect/Disease        | _____ Ivy Poisoning, etc. | _____ Mumps          |
| _____ Serious Injury            | _____ Convulsions                 | _____ Insect Stings       | _____ German Measles |
| _____ Eating Disorder           | _____ Diabetes                    | _____ Penicillin          | _____ Chicken Pox    |
| _____ Emotional Difficulties    | _____ Bleeding/Clotting Disorders | _____ Other Drugs         | _____ Hepatitis      |
| _____ Bedwetting                | _____ Abnormal Menstrual History  | _____ Food                | _____ Asthma         |

Explanation(s): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please notify us if this participant is exposed to any communicable disease during the three weeks prior to camp attendance.**

### IMPORTANT: MUST BE COMPLETED FOR ATTENDANCE

PERMISSION FOR TREATMENT: I hereby give consent for the Entreprep Summer Institute at the University of Delaware to carry out accepted procedures for diagnosis, medical and minor surgical treatment to my son/daughter/ward. Such care and treatment shall include: treatment of injuries, illnesses and administration of medication orally or by injection.

Although every effort will be made to reach parents in the event of an emergency, there are occasions when this is not possible. Therefore, we request that you sign the following: Permission is hereby granted for emergency procedures, such as surgery, treating fractures and whatever anesthetics are deemed necessary.

Signature \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

## Immunization History

Please record the date (month, day and year) of most recent immunization. **Please attach copy of official immunization record.**

<input type="checkbox"/> DTP (diphtheria, tetanus, pertussis)	<input type="checkbox"/> MMR (measles, mumps, rubella)	<b>Optional</b>
<input type="checkbox"/> dT (diphtheria, tetanus)	<input type="checkbox"/> Measles (hard, red, rubeola)	<input type="checkbox"/> Haemophilus influenza B
<input type="checkbox"/> Td (tetanus, diphtheria) (adult)	<input type="checkbox"/> Mumps	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> OPV (oral polio vaccine)	<input type="checkbox"/> Rubella (German measles)	<input type="checkbox"/> Varicella Zoster
<input type="checkbox"/> Tuberculin test	Result _____	

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## Medical Examination

This section should be completed by the examining physician. This examination is for determining fitness to participate in strenuous activities and should be performed within 12 months of camp date; examination for some other purpose within this time is acceptable.

Hgt. \_\_\_\_\_ Wgt. \_\_\_\_\_ B.P. \_\_\_\_\_ **Optional:** Hct. or Hgb. Test \_\_\_\_\_ Urinalysis \_\_\_\_\_

<input type="checkbox"/> Eyes	<input type="checkbox"/> Heart	<input type="checkbox"/> Extremities
<input type="checkbox"/> Glasses, contact lenses	<input type="checkbox"/> Genitalia	<input type="checkbox"/> Abdomen
<input type="checkbox"/> Ears	<input type="checkbox"/> Lungs	<input type="checkbox"/> Hernia
<input type="checkbox"/> Nose	<input type="checkbox"/> Skin	<input type="checkbox"/> Posture (Spine)
<input type="checkbox"/> Throat		

General Appraisal \_\_\_\_\_

## Recommendations and Restrictions

Dietary Restrictions \_\_\_\_\_  
\_\_\_\_\_

Allergies \_\_\_\_\_  
\_\_\_\_\_

Current medications (name, dosage frequency) \_\_\_\_\_  
\_\_\_\_\_

Strenuous activity \_\_\_\_\_  
\_\_\_\_\_

Other recommendations \_\_\_\_\_  
\_\_\_\_\_

Other Restrictions \_\_\_\_\_  
\_\_\_\_\_

I have examined the person herein described and have reviewed the Health History. It is my opinion that this participant is physically able to engage in camp activities, except as noted above.

Signature of Examining Physician \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_