Session 1 _____ Participant's Name _____
Session 2 _____
or
Summer Day _____

DUKE SUMMER HEALTH FORM

This form must be completed and signed by the participant's legal guardian. The information we ask you to provide is necessary in the event your child needs medical treatment while camp is in session. **This form will be returned to you if it is incomplete**. Please type or print in **black ink.**

PARTICIPANT INFORMATION

Participant's Name _____
Permanent Address _____ Date of Birth _____ Sex ___
City/State/Zip _____ Home Phone _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to contact first:	Backup contact (relative or friend):
Name _____	Name _____
Relation _____	Relation _____
Daytime Phone _____	Daytime Phone _____
Evening Phone _____	Evening Phone _____

INSURANCE POLICY INFORMATION

The above-named child is covered by health insurance: Yes No
If yes, provide the following information which is required by Duke University Medical Center to expedite treatment and to facilitate the billing process.

Policy Holder's (P.H.) Name _____ P.H.'s Date of Birth _____
Address _____ Relation _____
City/State/Zip _____ Occupation _____
P.H.'s Employer _____
Employer's Address _____
Insurance Company _____
Insurance Company's Address _____
Policy # _____ Plan # _____

MEDICAL TREATMENT CONSENT

I, the legal guardian of the above-named camper, authorize the Duke Summer Program staff to seek medical treatment for the camper as they see necessary at Duke University Medical Center or another nearby facility. I consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care subsequently deemed necessary by a licensed health care provider during the participant's session. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, and that it is given to provide the program staff authority to seek medical treatment, and to provide a licensed health care provider the authority to administer this treatment as s/he judges necessary to the above-named child. I accept responsibility for payment of all services rendered; I authorize any medical facility which renders services to release medical information necessary for the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, the Program staff will make a good faith effort to contact me or the above-named person(s) before seeking treatment. If this is not possible, I understand that the Program staff will notify me or my designee as soon a possible of any and all diagnoses and treatments.

_____ _____ _____

Legal Guardian's Signature Print Name Date

Participant's Name _____

Directions: Completion of this form by a parent or guardian is required before a student can participate. Please answer all questions. **Incomplete forms will be returned to you for the missing information**. Please type or print in black ink. Attach any specific recommendations from your physician to this form.

DOES THE PARTICIPANT CURRENTLY HAVE ANY OF THE FOLLOWING? (if yes, please describe)

Drug allergies: _____
Food allergies: _____
Allergies to insect bites: _____
Special dietary needs: _____
Asthma: _____
Frequent headaches: _____
Dizziness or seizures: _____

LIST: Other health problems: _____
_____

Limitations of Activities: _____
_____

Medications the camper is currently taking:_____
_____
_____

(**Please note:** Our staff cannot administer any medications, prescription or non-prescription to campers. This includes over-the-counter medicines like Advil or Tylenol for minor headaches or pains. If the camper will need to take medications while attending our program, s/he must bring the medication to camp and assume responsibility for taking it as needed or indicated.)

Will your son/daughter require any specific treatment for a medical/emotional condition while participating in our program? If yes, please explain. yes _____no
_____
_____

MEDICAL HISTORY

IMMUNIZATION DATES:
Measles _____
Mumps _____
Rubella _____
OR MMR_____
Last Tetanus _____
(DPT, TT or TD)
Polio Series completes _____

Date of last medical check-up: _____
Hospitalizations in the past 5 years: Describe
_____
_____
_____
_____
_____
_____

PHYSICIAN'S INFORMATION *(to be completed by physician)* Please **PRINT** the following information:

Physician's Name: _____
Address: _____
City/State/Zip _____
Telephone _____

I have examined the above named participant and found she/he to be able to participate in all activities of the Duke University _____ Summer Program.

Physician's Signature _____ Print Name _____ Date _____