THE
UNIVERSITY
OF RHODE ISLAND
DIVISION OF
ADMINISTRATION
AND FINANCE

THINK BIG WE DO

RISK MANAGEMENT
210 Flagg Road, Suite 213, Kingston, RI 02881 USA p: 401.874.2591 f: 401.874.9101 web.uri.edu/businessservices/riskmanagement

HEALTH HISTORY FORMS

Participant/Camper Name (please print): _____

Name of Family Physician & Address: _____ Office Number: _____

Please indicate yes or no to the following questions:	YES	NO
1. Had a recent injury or infectious disease?	___	___
2. Have frequent headaches?	___	___
3. Ever been knocked unconscious?	___	___
4. Wear glasses, contacts or protective eye wear?	___	___
5. Ever had frequent ear infections or have ear tubes?	___	___
6. Ever had seizures?	___	___
7. Have an orthodontic appliance being brought to Camp?	___	___
8. Have asthma or breathing disorders?	___	___
9. Have an eating disorder?	___	___
10. Does the participant have Epilepsy?	___	___
11. Ever had emotional difficulties for which professional help was sought?	___	___
12. Has the participant had a routine physical examination in the past twelve months?	___	___
13. The participant is NOT current with all immunization shots?	___	___

14. Please explain any "yes" answers, noting the question number: Attach additional paper if needed
15. May Camp staff, apply sunscreen on your child?
16. Use this space is to provide any additional information about the camper's behavioral, emotional, and/or mental health issues that URI's Camp authorized personnel should be aware of:

_____

_____

17. PHYSICAL ACTIVITY RESTRICTIONS (i.e., what cannot be done, what adaptations or limitations are necessary):
Any restrictions: ____ NO ____YES - please explain:

_____

_____

Participant/Camper Name (please print): _____

ALLERGIES (*if applicable*)

___ **YES** this camper has allergies (if yes, please list): **-OR-** ___ **NO** this camper does not have

Medication Allergies (please list): Describe reaction & management of the

_____ _____

_____ _____

Food Allergies (please list): Describe reaction & management of the

_____ _____

_____ _____

Other Allergies Including Insect Stings, Hay Fever, Animal Dander, etc. (please list and describe reaction & management of the reaction):

_____ _____

_____ _____

If camper requires medication for allergic reactions, please bring two (2) doses and Parents/Legal Guardian must present information to URI's authorized personnel at

MEDICATIONS (if applicable)

Please list ALL medications taken routinely (including over-the-counter or non-prescription drugs). Bring enough medication to last the entire week of Camp. Keep it in the original package/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, dosage, the campers name and the frequency times of administration. I will provide written, signed authorization from the physician(s) for each medication. Attach additional pages for more medications if needed.

_____ YES: this camper takes medication as follows: -OR- _____ NO: this camper does not take medication(s)

Med #1:_____ Dosage: _____

Specific times taken each day: _____ Reason for taking: _____

Med #2:_____ Dosage: _____

Specific times taken each day:_____Reason for taking: _____

*** ***Please keep all medications in a zip lock plastic bag that is labeled (print) with the campers full name & age.***

CONSENT TO SECURE MEDICAL TREATMENT

IMPORTANT - This information must be complete and submitted to URI for attendance to the camp.

Participant/Camper Name (please print): _____

Consent to Secure Medical Treatment Authorization: I herby give permission to have my child treated by the URI's authorized personnel, to provide appropriate health care, to their ability and level of training, administer prescribed medications (if authorized by a physician) and to perform and seek first-aid medical treatment. In the event that my child's behavior is felt to be unsafe or unmanageable, or if an illness or injury should arise in which a doctor's diagnosis is required, I authorize the Camp Director to dismiss my child early, in which case I will assume responsibility for arranging transportation for my child from the Camp at the time specified by the Camp management staff. In the event of an emergency requiring medical attention beyond first aid, I hereby grant permission to a physician or hospital personnel designed by URI authorized personnel to attend to my child in the event that I cannot be reached though my emergency contact phone number(s).

I agree to the release of any records necessary for insurance purposes. I give permission to URI's management staff to arrange necessary transportation for my child for emergency situations. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp management to secure and administer treatment and if necessary, hospitalization for the person named above**. I also understand that any and all expenses incurred by a medical emergency will be covered by myself and/or my insurance carrier, and will not be covered by the University of Rhode Island, Rhode Island Department of Education, their Agents, Employees and/or the State of Rhode Island.**

I acknowledge that the Emergency Contact Information, the Consent to Secure Medical Treatment Authorization and all Health History Forms for the Camper is correctly filled out to the best of my knowledge.

Signature of Parent/Guardian:_____Date: _____

Parent/Guardian Name (print): _____

Relationship to Minor Child: _____

PARENTS/LEGAL GUARDIAN - YOUR SIGNATURE INDICATES CONSENT TO PROVIDE HEALTH CARE, ADMINISTER PERSCRIBED MEDICATIONS AND SEEK EMERGENCY MEDICAL TREATMENT.