**Medical History/Release­­**

***Parents or Guardians***: This form must be filled out, signed and turned in BEFORE the student may remain on campus for camps or conferences. It may be filled out on your computer and then printed for signature and submission.

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| --- | --- | --- |
| ***Sports Camp Attending***  Defender Basketball  Lady Defender Basketball  Defender Soccer | ***Conference Attending***  Teen Leadership Conference  Radiate | Clarks Summit University will have trained medical personnel on duty with 24-hour service available. Numerous area hospitals are within several miles of the school. If you are not available for consent, the hospital medical staff may proceed with diagnostic and medical treatment. |

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| --- | --- | --- |
| Attendee’s Name | | Gender:  male  female |
| Street Address | | |
| City/State/Zip | | |
| Church/School you are attending with | | |
| Church/School City/State | | |
| Date of birth | Age | |
| Parent/Guardian Name #1 | Parent Phone | |
| Parent/Guardian Name #2 | Parent Phone | |

Insurance Information *(Please fill out completely!)*

|  |  |
| --- | --- |
| Does this insurance require Pre-Treatment Authorization?   yes    no | |
| Company Name | Phone Number |
| Policy Number | Group Number |
| Insurance Holder’s Name | Birth Date |
| Primary Care Physician | Phone Number |

Medical History *(Please fill out completely!)*

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| Medications |

All prescription medications are to be supplied and sent with the student. They MUST be in original containers. Please do NOT send medications in a “pill-minder” container. Please list all prescription medications here.

Please indicate if you want to be called if your child refuses medication. Please call me: yes no

|  |  |  |
| --- | --- | --- |
| Drug name | Dosage | Time(s) to be taken |
| Drug name | Dosage | Time(s) to be taken |
| Drug name | Dosage | Time(s) to be taken |
| Drug name | Dosage | Time(s) to be taken |

|  |  |  |  |
| --- | --- | --- | --- |
| Allergic Reactions | | | |
| Does the student have any allergies? | yes | no | bee stings   food     seasonal     other  Please list: |
| If yes to above, what happens and how is it treated? | | | |
| Will the student be carrying an epi-pen or inhaler? | yes | no | If “yes”, please specify: |
| Does the student suffer from asthma? | yes | no | If “yes”, please specify: |
| Is it sports induced? | yes | no | If “yes”, please specify: |
| Immunization Record | | | |
| Are all immunizations up to date including a tetanus within last 10 years? | yes | no |  |
| General Medical | | | |
| Are there any health or behavioral conditions that CSU should be aware of? | yes | no | If “yes”, please specify: |
| Is there a history of psychological issues *(including but not limited to)* cutting, eating disorders, bipolar, etc? | yes | no | If “yes”, please specify: |
| Does the student regularly take any medications? *(If brought to camp they must be in original container)* | yes | no | If “yes”, please specify: |
| Does the student currently have any infectious diseases or conditions? | yes | no | If “yes”, name, treatment, how long: |
| Is the student restricted from participating in any school physical education activity? | yes | no | If “yes”, please specify: |
| Were any complicating medical problems noted in last health examination? | yes | no | If “yes”, please specify: |
| Is the student currently under a physician’s care for a medical problem? | yes | no | If “yes”, please specify: |
| Other medical concerns for your student? | yes | no | If “yes”, please specify: |

Parent or Guardian Signature *(Required for camp/conference attendance)*

*I know of no reason(s), other than the information indicated on this form, why my son/daughter should not participate in prescribed activities. I acknowledge that events at Clarks Summit University may include, but are not limited to, use of CSU’s rock climbing wall and transportation to and from a ministry location in vehicles supplied by Clarks Summit University. I authorize the director(s) of this event to act for me according to their best judgment in any medical emergency. I also understand that I am responsible for health insurance for my child and will be responsible for all costs incurred for seeking medical attention on his or her behalf. I agree to hold CSU harmless for all occurrences relating to this event. I also understand that this event is voluntary on my part and has been initiated at my request.*

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| --- | --- |
| Parent Signature | Date |

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| --- | --- | --- |
| Contact Information | | |
| ***Sports Camps*** P: 570.585.9322 F: 570.585.9336 | ***TLC***  P: 570.585.9354 F: 570.585.9268 | ***Radiate*** P: 570.585.9361 F: 570.585.9268 |