2018 Summer Camps Registration Form

Cello Camp ~ Registration Deadline: June 22

(Mid Book 1 and above & at least 7 years old)

Monday, July 23 – Friday, July 27 9 am – 12pm each day

Location: SOM Rm TBD $145/week

Violin & Viola Camp ~ Registration Deadline: May 25

(for Mid Book 1 (Perp Mo) and above & at least 7 years old)

Monday, June 25 – Friday, June 29 8:30 – 12:00pm each day

Location: String Project Building $165/week

Camp includes: Violympics is our theme! Scales & Techniques, Ensemble Playing, Practice Time, Music Reading, & Fiddling/Pop Music Techniques

Fiddle Camp ~ Registration Deadline: June 22

(Violins, Violas, Cellos, & GUITARS, Perp Mo+, at least 7 years old & some reading recommended))

Monday, July 23 – Friday, July 27 2:00 – 4:00pm each day

Location: SOM Rm TBD $100/week

* Tuition is Non-Refundable after the registration deadline
* A minimum number of 10 students is required for each camp. If the minimum is not met, the camp could be cancelled and all payment returned to you.

CAMP REGISTRATION, PAYMENT & REQUIRED HEALTH FORMS (BELOW)

Student Name: _____ Camp (check):VIOLIN/VLA ___ $165
Instrument: _____ Age: _____ FIDDLE ___ $100
Current Suzuki Book:_____ Current Piece: _____ CELLO ___ $145

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Instrument: _____ Age: _____ FIDDLE ___ $100
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Instrument: _____ Age: _____ FIDDLE ___ $100
Current Suzuki Book:_____ Current Piece: _____ CELLO ___ $145

Parent Name:_____
Mailing Address:_____
Parent Phone: _____ Email:_____

Method of Payment: _____ Cash _____ Check (payable to: USC School of Music, Suzuki Strings) ____ Online TOTAL $_____

Please turn in /mail violin/viola/fiddle forms/payment to Samara Humbert-Hughes (shumberthughes@mozart.sc.edu) & cello forms/payment to Sarah Jackson (sjackson@mozart.sc.edu). USC School of Music, Suzuki Strings, 813 Assembly St., Columbia, 29208

Student Health Services
University of South Carolina

HEALTH HISTORY FORM

Form must be filled out before your appointment time
Please be sure all information is complete.

Thomson Student Health Center
1409 Devine St.
Columbia, SC 29208

_____
Today's Date

_____
Student's name (Last, First, Middle Initial)

_____
Emergency Contact Name Relationship

_____
Student's mailing address while at school City State ZIP

_____
Student's permanent mailing address

_____
Student's email address Preferred Phone (Cell #)

_____
City State ZIP Phone #

_____
Date of Birth SSN#

Have you completed a living will or
power of attorney for healthcare? _____

ALLERGY HISTORY

List any drug allergies: _____ Reaction: _____

List any allergies to materials (such as latex): _____ Reaction: _____

List any food allergies: _____ Reaction: _____

List any allergies to insects/other: _____ Reaction: _____

Are you receiving allergy injections? _____

CURRENT MEDICATIONS

List any drugs, medications, birth control, vitamins, and dietary supplements you currently use:

_____
_____

PERSONAL HISTORY

Indicate whether you have had any of the following medical issues:

Y	N	General Medical Health Problems
○	○	Acne
○	○	Anemia
○	○	Anxiety
○	○	Asthma/Lung disease
○	○	Bleeding problem
○	○	Blood clots in legs or lungs
○	○	Broken bones
○	○	Cancer
○	○	Cerebral palsy
○	○	Chicken pox
○	○	Colitis, ulcerative/Crohn's disease
○	○	Concussion
○	○	Congenital defect
○	○	Diabetes
○	○	Epilepsy, seizures
○	○	Hearing loss

Y	N	
○	○	Heart murmur/other heart problems
○	○	Hepatitis
○	○	High blood pressure
○	○	High cholesterol
○	○	Irritable bowel
○	○	Kidney infection, stones
○	○	Migraine headaches
○	○	Mononucleosis
○	○	Pneumonia
○	○	Rheumatic fever
○	○	Rheumatoid, other arthritis
○	○	Seasonal allergies
○	○	Scoliosis
○	○	Sickle cell
○	○	Thyroid problems
○	○	Tuberculosis or positive PPD
○	○	Ulcers

Y	N	Men's Health Issues
○	○	Bladder Infection
○	○	Breast mass or enlargement
○	○	Prostate infection
○	○	Steroid use
○	○	Testicular mass or lump

Y	N	Mental Health
○	○	Bipolar disorder
○	○	Depression
○	○	Eating disorder (anorexia, bulimia)
○	○	Substance abuse (alcohol, drugs)

Y	N	Women's Health Issues
○	○	Abnormal Pap Smear
○	○	Bladder infection
○	○	Breast lump or cyst
○	○	Pregnancy

If yes to any of the above, please explain:

_____
_____
_____

SOCIAL HISTORY

TOBACCO
Do you smoke cigarettes?
- O Yes
- O No

If yes, how many packs per day?
# of packs _____

If yes, how many years?
# of years _____

ALCOHOL/DRUG USE
Do you drink alcohol?
- O Yes
- O No

If yes, how many drinks per week?
# of drinks _____

Do you use recreational drugs?
- O Yes
- O No

Have you used needles to inject drugs?
- O Yes
- O No

SEXUAL ACTIVITY
Sexual History:
- O Never sexually active
- O Sexually active in the past but not currently
- O Sexually active

If sexually active, partner(s) are:
Male / Female

Birth control method(s):
_____

Have you had a sexually transmitted infection?
- O Yes
- O No

DIET/EXERCISE
Do you drink coffee/tea/soda daily?
- O Yes
- O No

If yes, how many cups per day?
# of cups _____

Do you drink energy drinks?
- O Yes
- O No

If yes, how many per day?
# of energy drinks _____

How many days per week do you exercise for 30 minutes or more?
0 / 1 - 2/ 3 - 4 / 5+

FAMILY HISTORY
Has any family member in the last two generations (siblings, parents, grandparents) had any of the following?
If yes, who and when?

Y	N	Has a family member had?	Who?
O	O	Alcoholism	_____
O	O	Blood clots in legs, lungs	_____
O	O	Cancer	_____
O	O	Depression	_____
O	O	Diabetes	_____
O	O	Genetic disorder	_____

Y	N	Has a family member had?	Who?
O	O	Heart disease	_____
O	O	High blood pressure	_____
O	O	Liver disease	_____
O	O	Stroke, blood vessel disease	_____
O	O	Suicide	_____
O	O	Other: _____	_____

SURGICAL HISTORY
List all prior operations you have had, with dates (i.e. appendectomy, pinning of fracture):

_____
_____
_____

HOSPITALIZATIONS
List any hospitalizations not included in surgical history (i.e. overnight stay):

_____
_____
_____

ADDITIONAL INFORMATION
Is there anything about your physical, mental or emotional health that would be helpful to Student Health Services in providing you medical care?

_____
_____

READ, CHECK AND SIGN BELOW.

- O I am aware that Student Health Services charges for some services that are not covered under the student health fee. I accept personal responsibility for the payment of incurred charges at the time services are rendered.
- O I understand that I am responsible for filing outpatient charges with my health insurance carrier and acknowledge that my responsibility to the University is unaffected by the existence of health insurance coverage.
- O I authorize any medical treatment for myself that may be advised or recommended by the medical providers at Student Health Services.
- O I have personally supplied the above information and attest that it is true and complete to the best of my knowledge. I understand that the information contained on this form and in my medical records is strictly confidential and will not be released to anymore other than my healthcare provider, without my written authorization unless required by law. If I should be ill or injured or otherwise unable to sign the appropriate medical release form, I give my permission to Student Health Services to release information from my medical record to a physician, hospital, or other medical professional involved in providing me with emergency treatment and/or medical care.

_____
Signature of patient Date

_____
Signature of legal guardian (if patient is under 18) Date

_____
Signature of reviewing medical provider Date

Student **Health** Services

University of South Carolina

Permission to File Claims with Your Health Insurance Provider

Financial Information and Authorization to Process Insurance Claims

It is recommended that all USC students be covered by health insurance either with an individual student policy or through their family policy. Student Health Services will file insurance claims on behalf of patients and clients. The filing of claims does not guarantee either full or partial payment by the insurance company. SHS is a participating provider only for the USC Student Health Insurance Plan through AIG.

SHS is not a participating provider for other health insurance plans, including HMOs and those covering USC or state employees and their dependents. The Thomson Student Health Center Pharmacy (TSHC) is contracted and approved to file claims for many insurance plans for prescriptions, whether written by SHS providers or others. Students are urged to check with the TSHC Pharmacy staff to see if their policy is covered before attempting to fill prescriptions elsewhere. Students and their parents are encouraged to contact their insurance company to request that SHS be enrolled as a participating provider in their plan.

By signing this acknowledgment, you are indicating that you have read and understand the above information and authorize the release of any medical or insurance information to the insurance company which is necessary to process claims for services rendered by this facility. You also acknowledge that you authorize your insurance company to distribute the payment of my coverage directly to the provider rendering services. You understand that you are fully responsible for all charges regardless of your insurance benefits. As a student at USC, you understand that you are responsible for any charges incurred by your spouse if treated at Student Health Services. You authorize the use of this acknowledgment in lieu of signature on all insurance submissions. You may elect to pay any bill in full in lieu of submitting a claim for insurance reimbursement.

You also understand that by filing insurance claims, your private health information may be disclosed to the insurance policy holder.

*** An insurance ID card must be presented at Student Health Services in order to file claims with your insurance plan. A copy of the insurance card is not acceptable.***

Print Name	Signature	Date

Student **Health** Services

University of South Carolina

TREATMENT AGREEMENT &
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Information

Patient Name:_____ Date of Birth:_____

USC ID and/or Last 4 of SSN:_____

CONSENT FOR TREATMENT/ CARE:

I hereby authorize any medical or mental health treatment for myself that may be advised or recommended by the health care providers of USC. I am aware that the practices of medicine and psychology are not an exact science and I understand that no guarantees have been made to me about the results of treatments, examinations, procedures, or analysis.

ACKNOWLEDGMENT:

I attest that this office has given me a copy of its Notice of Privacy Practices to review. The Notice describes how medical information about me may be used and disclosed and how I can gain access to this information. I understand that it is the responsibility of this office to provide me with a copy of its Notice on the first services encounter after August 25, 2013. If my first date of service with this office was due to an emergency, I understand that it is the office's responsibility to provide me with this Notice and obtain my signature as acknowledgment of receipt as soon as possible following the emergency.

CHECK ALL THAT ARE TRUE:

- ☐ I have reviewed USC's Notice of Privacy Practices.
- ☐ The health care provider/agent has given me the chance to discuss my concerns and questions about the privacy of my health information.

_____	_____	_____
Patient/Legal Representative Signature	If signor is not the patient, state relationship	Date

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USC INTERNAL STAFF USE ONLY

COMPLETE IF ACKNOWLEDGMENT FORM IS NOT SIGNED:

1. Was the patient given a copy of the Notice of Privacy Practices?
   ☐ Yes ☐ No

2. If the form is not signed, explain why and your efforts to obtain the patient's signature:

_____

_____

_____	_____	_____
Staff Signature	Print Your Name & Title	Date