University of South Carolina Program for Minors
Health History, Disclosure and Consent Forms

Instructions for custodial parent/legal guardian of child participant: *Please complete the health history and disclosure form, sign and date where indicated, and submit the completed form by the program due date. Completed and signed forms must be on file before a child can be permitted to participate in the program.*
Instructions for program director: *Please confirm that all participant forms are complete before the child participates in your program. Contact minors@email.sc.edu with questions or concerns. Maintain records of signed consent and release for seven (7) years after program conclusion.*

Participant Name: _____
Last *First* *Middle Initial*

Program Dates: from _____ **to** _____
Month/Day/Year *Month/Day/Year*

Birth Date: _____ **Male:** ___ **Female:**____
Month/Day/Year

Participant Home Address:_____
Street & Number

_____
City *State* *Zip*

Custodial Parent/Guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship: _____ Preferred Phone: (___)_____
Email: _____

Home Address:_____
Street & Number, City, State, ZIP

Second parent/guardian or other emergency contact:

Name: _____ Relationship: _____ Preferred Phone: (___)_____

Email: _____

Additional contact in event parents(s)/guardian(s) cannot be reached *(optional)*:

Name: _____ Relationship: _____ Preferred Phone: (___)_____

Allergies: ☐No known allergies. ☐This participant is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other (Please describe below what the participant is allergic to, the reaction seen and any other relevant details.)

Diet, Nutrition: List any food restrictions or special needs other than the allergies listed above.

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Medications required to be taken by the participant. The participant must self-administer all medications.

Prescription Medication: ☐ This participant will NOT take any medications while in the program
☐ This participant takes medications as follows (attach additional pages if needed)

Medication	Dosage:	Times taken each day (e.g.: with breakfast, lunch, dinner, bedtime, or other)	Reason for taking:

I authorize **self-medication** by my child for the above medication/s. I also affirm that s/he has been instructed in the proper self-administration of the prescribed medication(s) by her/his attending physician. I agree to indemnify and hold harmless for any and all purposes, the University of South Carolina, the Board of Trustees for the University of South Carolina, and their members, officers, servants, agents, volunteers, or employees against any claims that may arise relating to my child's self-administration of prescribed medication(s).

_____ _____ _____
Signature of Custodial Parent/Guardian_____ Date_____ Relationship to participant_____

Non-prescription medications: Some medications (e.g. Tylenol, Pepto-Bismol, Neosporin) may be stocked by the program and used on an ***as needed basis*** to manage illness and injury. Please list any non-prescription medications that the participant should ***not*** be given:

Immunization History: Provide the approximate date for each immunization. Alternatively, submit a copy of the child's immunization record from health-care providers or state government with this form.

	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most recent dose Month/Year
Diptheria, tetanus, pertussis (DTap) or (DdaP						
Tetanus booster (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)						
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) test	Date		Negative?		Positive?	

If the child **has not been fully immunized**, attest that you understand and accept the risks to them from not being fully immunized.

Signature of Custodial Parent/Guardian _____ Date: _____ Relationship to Participant: _____

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Health History: Check "yes" or "no" for each statement. Explain, "yes" answers below.
Has/does the participant:

1. Ever been hospitalized? ☐Yes ☐ No
2. Ever had surgery? ☐Yes ☐No
3. Have recurrent/chronic illness? ☐Yes ☐No
4. Had recent infectious disease? ☐Yes ☐No
5. Had recent injury? ☐Yes ☐No
6. Have diabetes? ☐Yes ☐No
7. Had seizures? ☐Yes ☐No
8. Had headaches? ☐Yes ☐No
9. Have history of bedwetting? ☐Yes ☐No
10. Have any skin problems? ☐Yes ☐No
11. Wear glasses, contacts or protective eyewear? ☐Yes ☐
12. Had fainting or dizziness? ☐Yes ☐No
13. Ever had back/joint problems? ☐Yes ☐No
14. Passed out/had chest pain during exercise? ☐Yes ☐No
15. Have problem with falling asleep/sleepwalking? ☐Yes ☐No
16. Had mononucleosis during the past 12 months? ☐Yes ☐No
17. If female, problems with periods/menstruation? ☐Yes ☐No
18. Have problems with diarrhea/constipation? ☐Yes ☐No
19. Had asthma/wheezing/shortness of breath? ☐Yes ☐No
20. Foreign travel in the past nine months? ☐Yes ☐No

Explanations:

Mental, Emotional, and Social Health: Respond to each statement and explain "Yes" answers in the space below, noting the number of the question. **Has/Does the participant:**

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐Yes ☐No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐Yes ☐No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐Yes ☐No
4. Had a significant life event that continues to affect the participant's life? (History of abuse, death of loved one, family change, adoption, foster care, new sibling, survived a disaster) ☐Yes ☐No
5. Any other issue that we have not asked about? ☐Yes ☐No

Explanations:

Health Care Providers:

Name of participant's primary doctor(s): _____ Phone: (_____) _____

Name of dentist(s):_____ Phone: (_____) _____

Medical Insurance Information: All participants must be covered under a current, active insurance policy.

Submit a copy of your insurance card with this form; copy both sides of the card so information is readable.

Insurance Company_____ Policy Number _____

Subscriber Name_____

Insurance Company Phone Number (_____)_____

Participant Name: _____
Last *First* *Middle Initial*

PARENT/LEGAL GUARDIAN AUTHORIZATION AND PERMISSION TO TREAT:

1. I have reviewed the activities described in this program and attest that my child can participate in those activities.
2. This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed program activities, except as noted by me and/or an examining physician.
3. I hereby give permission to the medical personnel selected by the program director to provide routine health care: to administer medications when necessary, order x-rays, routine tests, treatment, to release any records necessary for insurance purposes, to obtain a copy of my child's health record and/or to speak with health care providers regarding my child's health status, and to provide or arrange for necessary related transportation for me/or my child.
4. If I cannot be reached in an emergency, I hereby give permission to the physician/health care provider selected by the program director to secure and administer treatment, including hospitalization, for my child.
5. I further give permission to photocopy this form.
6. I warrant I am the custodial parent or authorized legal guardian of the participant in the program.
7. I warrant that I am 18 years of age or older.

Custodial Parent / Guardian Name *Signature* *Date*