## HEALTH HISTORY FORM

**Summer Camp**  
Center for Health and Well-Being  
Mailing Address  
1409 Devine St.  
Columbia, SC 29208

Form must be filled out before child arrives to camp.  
Please be sure all information is complete.

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**Camper’s name** (Last, First, Middle Initial)

**Camper’s mailing address**  
City  
State  
ZIP

Parent or guardian’s email address

Camper’s Date of Birth

### 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, vitamins, and dietary supplements your child currently uses:

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### PERSONAL HISTORY

Indicate whether your child has had any of the following medical issues:

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>General Medical Health Problems</th>
<th>Y</th>
<th>N</th>
<th>Heart murmur/other heart problems</th>
<th>Y</th>
<th>N</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>o</td>
<td>o</td>
<td>Acne</td>
<td>o</td>
<td>o</td>
<td>Hepatitis</td>
<td>o</td>
<td>o</td>
<td>Other mental health</td>
</tr>
<tr>
<td>o</td>
<td>o</td>
<td>Anemia</td>
<td>o</td>
<td>o</td>
<td>High blood pressure</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>o</td>
<td>o</td>
<td>Anxiety</td>
<td>o</td>
<td>o</td>
<td>High cholesterol</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>o</td>
<td>o</td>
<td>Asthma/Lung disease</td>
<td>o</td>
<td>o</td>
<td>Irritable bowel</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>o</td>
<td>o</td>
<td>Bleeding problem</td>
<td>o</td>
<td>o</td>
<td>Kidney infection, stones</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>o</td>
<td>o</td>
<td>Blood clots in legs or lungs</td>
<td>o</td>
<td>o</td>
<td>Migraine headaches</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>o</td>
<td>o</td>
<td>Broken bones</td>
<td>o</td>
<td>o</td>
<td>Mononucleosis</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>o</td>
<td>o</td>
<td>Cancer</td>
<td>o</td>
<td>o</td>
<td>Pneumonia</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>o</td>
<td>o</td>
<td>Cerebral palsy</td>
<td>o</td>
<td>o</td>
<td>Rheumatic fever</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>o</td>
<td>o</td>
<td>Chicken pox</td>
<td>o</td>
<td>o</td>
<td>Rheumatoid, other arthritis</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>o</td>
<td>o</td>
<td>Colitis, ulcerative/Crohn’s disease</td>
<td>o</td>
<td>o</td>
<td>Seasonal allergies</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>o</td>
<td>o</td>
<td>Concussion</td>
<td>o</td>
<td>o</td>
<td>Scoliosis</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>o</td>
<td>o</td>
<td>Congenital defect</td>
<td>o</td>
<td>o</td>
<td>Sickle cell</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>o</td>
<td>o</td>
<td>Diabetes</td>
<td>o</td>
<td>o</td>
<td>Thyroid problems</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>o</td>
<td>o</td>
<td>Epilepsy, seizures</td>
<td>o</td>
<td>o</td>
<td>Tuberculosis or positive PPD</td>
<td>o</td>
<td>o</td>
<td></td>
</tr>
<tr>
<td>o</td>
<td>o</td>
<td>Hearing loss</td>
<td></td>
<td></td>
<td>Ulcers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes to any of the above, please explain:

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### SOCIAL HISTORY

**EXERCISE**  
How many days per week does your child exercise for 30 minutes or more?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>h</th>
<th>4</th>
<th>5+</th>
</tr>
</thead>
<tbody>
<tr>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DIET**  
*Does your child drink coffee/tea/soda daily?*

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>o</td>
<td>o</td>
</tr>
</tbody>
</table>

If yes, how many cups per day?

# of cups ______

*Does your child drink energy drinks?*

If yes, how many per day?

# of energy drinks ______

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As a parent or legal guardian, I

Permission to File Insurance:  

Permission to Treat:  

IMMUNIZATIONS  I certify that my child is or is not compliant with the below immunizations:

SURGICAL HISTORY List all prior operations 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 child's physical, mental or emotional health that would be helpful to Student Health Services in providing medical care?

READ, CHECK AND SIGN BELOW.

- As a parent or legal guardian, 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.
- As a parent or legal guardian, 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.
- As a parent or legal guardian, I authorize any medical treatment for my child that may be advised or recommended by the medical providers at Student Health Services.
- As a parent or legal guardian, I have personally supplied the above information and attest that it is true and complete to the best of my knowledge. As a parent or legal guardian, I understand that the information contained on this form and in my child's 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 my child should be ill or injured or I am otherwise unable to sign the appropriate medical release form, I give my permission to Student Health Services to release information from my child's medical record to a physician, hospital, or other medical professional involved in providing me with emergency treatment and/or medical care.
- Permission to Treat: I hereby authorize any medical treatment for my child that may be advised or recommended by the health care providers of USC. I am aware that the practices of medicine 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 of Receipt of Notice of Privacy Practice: I attest that this office has given me a copy of its Notice of Privacy Practices to review.
- Permission to File Insurance: Student Health Services will file insurance claims on my child's behalf. A current insurance ID card must be presented and maintained on file at Student Health Services in order to file claims with your insurance plan. The filing of claims does not guarantee either full or partial payment by the insurance company. I understand that I am responsible for any unpaid balances.

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. I also acknowledge that you authorize your insurance company to distribute the payment of your coverage directly to the provider rendering services.

Signature of parent or legal guardian  Date

Signature of reviewing medical provider  Date