

FERRIS STATE UNIVERSITY Medical History Report

This form must be completed, signed and returned by parent or guardian before participation will be allowed

It is the aim of Ferris State University to have each participant enjoy as complete an experience as is possible within his/her capabilities. Your medical history will provide the essential information needed to meet that goal. The history is required primarily to determine what adjustments, if any, should be made in schedules of activities to meet the individual needs of participants, and that the participant may safely participate in those activities. **NOTE: FERRIS STATE UNIVERSITY RESERVES THE RIGHT TO DETERMINE THE EXTENT OF PARTICIPATION OF EACH PARTICIPANT IN ALL ACTIVITIES CONDUCTED BY THE UNIVERSITY.** The information will also be used in the event of any participant injuries.

PLEASE PRINT

PARTICIPANT LAST NAME , FIRST, MIDDLE	AGE BIRTHDATE
HOME STREET ADDRESS	HOME CITY, STATE, ZIP
PARENT/GUARDIAN NAME	DAYTIME TELEPHONE HOME TELEPHONE () ()

IN CASE OF EMERGENCY, CONTACT (AVAILABLE 24 HOURS)

LAST NAME, FIRST, MIDDLE	RELATIONSHIP	TELEPHONE ()
HOME STREET ADDRESS	ADDITIONAL ADDRESS	
HOME CITY, STATE, ZIP	CITY, STATE, ZIP	ADDITIONAL TELEPHONE ()

FAMILY HISTORY

Please list here any close relatives who have had the following illnesses.

	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
Asthma/ Hay fever				Kidney disease			
Arthritis				Stomach disease			
Diabetes				Tuberculosis			
Epilepsy/ convulsions				Heart disease			

PERSONAL HISTORY

Check box beside those medical problems participant has had or now has.

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Measles (Rubella) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney, bladder problems | <input type="checkbox"/> Ankle sprains & Knee injuries |
| <input type="checkbox"/> Rubella (3-day measles) | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Chest pain <input type="checkbox"/> Mild <input type="checkbox"/> Severe | |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Tension or depression | <input type="checkbox"/> Chronic pain <input type="checkbox"/> Mild <input type="checkbox"/> Severe | |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Palpitations | |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Head Injury | <input type="checkbox"/> High blood pressure | |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Hay fever, asthma | <input type="checkbox"/> Heart problem or murmur | |
| <input type="checkbox"/> Eye trouble | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> Ear trouble | <input type="checkbox"/> Jaundice, liver disease | <input type="checkbox"/> Back problems | |
| <input type="checkbox"/> Throat problems | <input type="checkbox"/> Stomach, intestinal trouble | <input type="checkbox"/> Sexually transmitted diseases | |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Gall bladder trouble | |
| <input type="checkbox"/> Joint problems | <input type="checkbox"/> Allergies to drugs, food | <input type="checkbox"/> Neurological disorder | |
| <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Seizure disorder/Epilepsy | <input type="checkbox"/> Other _____ | FEMALES ONLY:
<input type="checkbox"/> Irregular periods
<input type="checkbox"/> Severe cramps
<input type="checkbox"/> Excessive flow
....Over |

Please list any ILLNESSES, INJURIES, OR SURGERIES participant has had within the past five years. Use additional sheet, if necessary.

Type of illness, injury, or surgery	Name of hospital	City & State	Date	Current Status

Please comment in detail in the space below on any medical condition checked with an "X" in Personal History.

Does participant have any health problem that requires periodic evaluation or testing Yes No (Give details)

List any medications participant is receiving regularly (medications that are required by participants should accompany them at camp).

List any allergies that the participant has (e.g. to drugs, bees, foods, etc.):

List any other health or personal concerns that Ferris State University should be aware of in regard to the participant. Include any physical conditions that might limit or prevent participation in certain physical activities. Describe such conditions and limitations on activities.

Date of last tetanus injection.

Date of last physical examination.

Name of Primary Physician: _____

Address: _____

Phone No. _____

Please enter all information from your insurance card or attach a copy of the front and back of the card.

Front of Card	Back of Card

I Declare that My Answers and Statements Are Correctly Recorded, Complete and True to the Best of My Knowledge and Belief.

DATE	SIGNATURE OF PARENT OR GUARDIAN
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PARENT/GUARDIAN MUST SIGN AND RETURN