FAIRMONT STATE UNIVERSITY

FAIRMONT STATE UNIVERSITY ATHLETICS' CAMPS/CLINICS
Physical Form

PART I - Camp Health Form

Camper's Name: ______________________________ Date: __________________________

Camper Cell Number: ___________________ Camper Email Address: _____________________

Name of summer Camp/Program and Date(s) of Event: __________________________________

Camper's School: _________________________________

Camper's Current Grade Level (as of Fall 2021): ______________

Camper's Graduation Year: _______________

Camper's High School Coach: ______________________

Coach's Contact Information: __________________________

Gender Identity (Check One): Male Female Self-Identify Prefer Not to Share

Date of Birth: ___________________ SSN: _________________

Address: ____

Parent/Guardian Name: _________________________ Relationship to Camper: ___________

Parent/Guardian Contact Number: Home: _______________ Cell/Other: ________________

Secondary Contact Name: _________________________ Relationship to Camper: ___________

Secondary Contact Number: Home: _________________ Cell/Other: ________________

Insurance Company Name: ____

Policy Number: ____________________ Group Number: ______________

Policy Holder Name: ____

Parent or Guardian Signature: ______________________________________

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Important: Please notify the camp if this camper is exposed to any communicable disease during the three weeks prior to camp attendance.

PART II - PARENTAL CONSENT

I acknowledge that Fairmont State's Health Personnel has the final authority to determine whether a student is removed or withheld from participation due to illness, injury or other medical condition. In addition, clearance for the individual to return to camp activity is solely the discretion of Fairmont State University.

I affirm that this health history is correct to the best of my knowledge and belief, and I hereby give permission for the person herein described to engage in all prescribed camp activities, except as indicated here: ____

____

I give my permission for Fairmont State Student Health to administer any medications needed and to provide and arrange for any necessary medical treatment of the camper while at Fairmont State University, including onsite and offsite emergency care. I accept responsibility for the costs of all medical treatment.

I acknowledge that Fairmont State University Student Health Services will make every effort to contact the parent/guardian listed above in the case of an emergency. I also acknowledge that emergency medical treatments will not be withheld or delayed based on whether the parent/guardian has been contacted in order to maintain safety of the minor involved.

I consent to Fairmont State University's use of the camper's name and likeness in promotional literature, media stories/reports, and other materials related to Fairmont State University and the subject camp.

____ _____________

Print Name Date

____

Signature

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PART II – CAMPER'S MEDICAL HISTORY
(Parent or Guardian Should complete Prior to Examination)

Name: ______________________ Date of Birth: ___/___/___ Grade: _____ Age: _____

Has the camper ever had:

Yes	No	Chronic or recurrent illness (Diabetes, Asthma, Seizures, etc.)?
Yes	No	Any hospitalizations?
Yes	No	Any surgery (except tonsils)?
Yes	No	Any injuries that prohibited your participation in sports?
Yes	No	Dizziness or frequent headaches?
Yes	No	Knee, ankle or neck injuries?
Yes	No	Broken bone or dislocation?
Yes	No	Heat exhaustion/sun stroke?
Yes	No	Fainting or passing out?
Yes	No	Have any allergies?
__Yes	__No	Concussion? If yes, provide the date:_______

Does the student:

Yes	No	Have any problems with heart/blood pressure?
Yes	No	Has anyone in your family ever fainted during exercise?
Yes	No	Take any medication? List: ________ ______________________________
Yes	No	Wear glasses: ____; Contact Lens: ____: Dental appliances: ____
Yes	No	Have any organs missing (eye, kidney, testicle, etc.)? Identify: ____________
Yes	No	Has it been longer than 10 years since your last tetanus shot?
Yes	No	Have you ever been told not to participate in any sport?
Yes	No	Do you know of any reason this camper should not participate in camp?
Yes	No	Have a sudden death history in your family?
Yes	No	Develop coughing, wheezing, or unusual shortness of breath?
Yes	No	Have a family history of heart attack before age 50?
__Yes	__No	Do you have any problems with your menstrual periods?

Please explain any "Yes" answer or provide any other medical concerns: ______________________
____
____
____
____

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I affirm that the information provided above is correct to the best of my knowledge and belief information provided above is give permission for Fairmont State University or other medical personnel to give treatment at any camp event for any injury.

____ ______________

Print Name Date

____

Signature

PART IV - PHYSICIAN'S HEALTH VERIFICATION

A. Vital Signs

Height: _______ Weight: ______ Pulse: ______ Blood Pressure: ______

Visual Acuity: Uncorrected ____/____; Corrected ____/____; Pupils Equal Diameter: __Y __N

B. Screening Physical Exam (This exam is not meant to replace a full physical examination done by your private physician).

Mouth			**Respiratory**			**Abdomen**		
Appliances	Y	N	Symmetrical breath sounds	Y	N	Masses	Y	N
Missing/Loose Teeth	Y	N	Wheezes	Y	N	Organomegaly	Y	N
Skin/Lymphatic System			**Cardiovascular**			**Genitourinary** (males only)		
Enlarged lymph nodes	Y	N	Murmur	Y	N	Inguinal hernia	Y	N
Skin – Infectious lesions	Y	N	Irregularities	Y	N	Bilaterally descended testicles	Y	N
Peripheral pulses equal	Y	N	Murmur with Valsalva	Y	N			
Musculoskeletal (Note any abnormalities)								
Neck	Y	N	Elbow	Y	N	Hamstrings	Y	N
Knee/Hip	Y	N	Shoulder	Y	N	Wrist	Y	N
Ankle	Y	N	Scoliosis	Y	N			

C. Recommendations based on the above evaluation:

After my evaluation, I give my

_____ Full Approval;

_____ Full approval; but needs further evaluation by Family Dentist____; Eye Doctor_____;

Family Physician_______________________________; Other______;

_____ Restrictions/Limitations While at This Camp for This Camper:

____

____

_____ Denial of approval for the following reasons:

____.

A sports camp / clinic participant shall not be permitted to attend a particular camp unless this camp health form with a doctor's signature is completed and returned to the appropriate camp staff no later than the day of registration.

Doctor's Name (Print): _______________________________________

Doctor's Signature: _______________________________ Date: ___________

MD DO DC Advanced Registered Nurse Practitioner Physician's Assistant (Check One)