SUMMER MEDICAL FORM (MF -1)

The University of the South
735 University Avenue
Sewanee, Tenn 37383

IMPORTANT to all summer participants:

The completion of this form is a prerequisite for registration and participation in designated summer programs at The University of the South. Please answer ALL questions and return this form to: The University of the South, 735 University Avenue, Sewanee, TN 37383 or scan and email to sei@sewanee.edu. *PLEASE MAKE SURE YOU SEND IT TO THE ATTENTION OF THE PROGRAM THAT YOU WILL BE PARTICIPATING IN. ALSO, IT IS CRUCIAL THAT YOU SEND A COPY OF THE FRONT AND BACK OF YOUR MEDICAL INSURANCE CARD!

Name of Student: _____ **Sex: (circle one)** Male Female Other

Gender: (If other, please explain how you identify yourself) _____

_____

Name(s) of Parents/guardian or spouse: _____

Address(s): _____ **Home Phone # (s):** (_____)_____

_____ **Cell Phone # (s):** (_____)_____

Date of Birth (MM/DD/ YYYY): _____/_____/_____ **Social Security #:** _____-_____-_____

Person to reach in case of an emergency (Name & Phone #): _____

(_____)_____

DATE OF LAST TETANUS BOOSTER (MM/DD/YYYY): _____/_____/_____

CHRONIC MEDICAL PROBLEMS: _____ **DAILY MEDICATIONS:** _____

_____ _____

_____ _____

MEDICATION ALLERGIES: _____

_____

INSURANCE INFORMATION (please include copy of card):

Name of Company: _____ **Group #:** _____

Policy #: _____ **Address of Company:** _____

_____

SUMMER MEDICAL FORM (MF-2)

IMMUNIZATION HISTORY

Have you been immunized against...

			Month/year
Mumps	Yes	No	_____
Measles-Rubella	Yes	No	_____
German measles-Rubella	Yes	No	_____
Tetanus	Yes	No	_____
Diphtheria	Yes	No	_____
Polio	Yes	No	_____

If you have had any of these diseases, please explain: _____

_____

_____

_____

_____

_____

_____

ALLERGY HISTORY

Are you allergic to...

Penicillin	Yes	No
Sulfa	Yes	No
Other Drugs	Yes	No
Foods	Yes	No
Pollen	Yes	No
Other	Yes	No

Explain all allergies & describe reaction: _____

_____

_____

_____

_____

_____

_____

*If you are to receive injections for allergies, please have your physician write dosage, frequency and duration of injections in an attachment signed and dated by the physician.

Yes No **Do you have any illnesses or conditions for which you are now being treated? If so, please provide details here.**

_____

Yes No **Are you now taking regularly any medications prescribed for you? (If so, please fill out MF-3)** _____

_____

Yes No **Are you now on a special diet? If so, give details.** _____

_____

Yes No **Have you ever received treatment for mental or emotional disorders? If so, please have physician furnish case history in an attachment signed and dated by the physician.**

PARENTAL PERMIT: The parents of all students under the age of 18 must sign the following consent form so that medical procedures may be promptly carried out and to avoid unnecessary delays occurring with treatment.

"I hereby give permission for the medical staff of The University of the South to perform such diagnostic, therapeutic, and operative procedures as they deem necessary for my son/daughter _____." We (I) agree that the transmission of these signed documents by facsimile or other electronic transmission are sufficient to replace original copies.

Date: (MM/DD/YYYY)_____/_____/_____ **Signed:** _____

Name Printed: _____

Relationship to student: _____

SUMMER MEDICAL FORM (MF-3) – Medication(s)

Medication: **_____ : This camper will not take any daily medications while attending SYWC summer program.**
_____: This camper will take the following daily medication(s) while at camp.

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. Please make sure all medications are properly labeled and packaged for the director to quickly identify. **These labels will need to show the student's name and how the medication should be given. Provide enough of each medication to last the entire time the student will be at Sewanee.**

Name of medication	Date started	Reason for taking it	When it is taken:	Amount or dosage	How is it taken
			_____ Breakfast _____ Lunch _____ Dinner _____ Bedtime _____ Other time _____		
			_____ Breakfast _____ Lunch _____ Dinner _____ Bedtime _____ Other time _____		
			_____ Breakfast _____ Lunch _____ Dinner _____ Bedtime _____ Other time _____		
			_____ Breakfast _____ Lunch _____ Dinner _____ Bedtime _____ Other time _____		

SUMMER MEDICAL FORM (MF-4) – Medical Conditions & Allergies

If you need more space to explain your child's allergies or special diet requirements, please do so here: _____

If you need to further explain your child's medical conditions or limitations in participation at SYWC, please do so here: _____