

UM Summer Camp Health Questionnaire
(To be filled out by Participant's Parent or Guardian)

Participant _____ **Birthdate** ____/____/____ **Sex:** M F

Address _____ **Phone** () _____ - _____

Family Physician _____ **Phone**() _____ - _____

Parent/Guardian _____ **Camp Type** _____

Medications: indicate medication(s) which is/are taken on a regular basis:

Medication Name _____ Dosage _____ Directions _____

Medication Name _____ Dosage _____ Directions _____

Note: Participant should bring an adequate supply of their medication(s) with them.

Explain any "yes" answers below:

Yes No

Nervous System: Has the participant ever:

- | | | | |
|----|--|--------------------------|--------------------------|
| 1. | had a head injury?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | been knocked out or unconscious?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | had a seizure?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | had a stinger, burner or pinched nerve?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | had any problems with his/her eyes or vision?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | worn glasses, contacts or protective eyewear?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Circulation: Has the participant ever:

- | | | | |
|-----|---|--------------------------|--------------------------|
| 7. | been dizzy or passed out during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. | had chest pain during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | tired out more quickly than their friends during exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | been told he/she has a heart murmur?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | had racing heart or skipped heartbeats?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. | had anyone in their family died of heart problems or sudden death before age 50?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Respiratory:

- | | | | |
|-----|--|--------------------------|--------------------------|
| 13. | Does the participant ever have trouble breathing or cough during or after exercise?..... | <input type="checkbox"/> | <input type="checkbox"/> |
|-----|--|--------------------------|--------------------------|

Musculoskeletal:

- | | | | |
|-----|---|--------------------------|--------------------------|
| 14. | Does he/she frequently have heat or muscle cramps?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. | Do he/she use any special equipment (pads, braces, neck rolls, mouth guards, etc.)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. | Has she/he had any injuries of any bones or joints?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> Head <input type="checkbox"/> Chest <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle
<input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Forearm <input type="checkbox"/> Hand <input type="checkbox"/> Thigh <input type="checkbox"/> Calf <input type="checkbox"/> Foot | | |

- | | | | |
|-----|--|--------------------------|--------------------------|
| 17. | Skin: Does she/he have any skin problems (itching, rashes, acne, etc.)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
|-----|--|--------------------------|--------------------------|

General:

- | | | | |
|-----|--|--------------------------|--------------------------|
| 18. | Has he/she ever had surgery or been hospitalized?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. | Has he/she had any other medical problems (infectious mono, diabetes, high blood pressure, etc.)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. | Is he/she taking any medications or pills?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. | Does he/she have any allergies (medicines, bees or other stinging insects)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. | When was the participant's last tetanus shot? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. | When was the participant's last measles immunization? _____ | | |

Females only:

- | | |
|-----|--|
| 24. | When was the participant's first menstrual period? _____ |
| 25. | When was the participant's last menstrual period? _____ |
| 26. | What was the longest time between the participant's periods last year? _____ |

Explain "Yes" answers:

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of Participant _____ **Date** ____/____/____

Signature of parent/guardian _____