2018 TEXAS STATE CHOIR CAMP
MEDICAL FORM

Please complete and return the following information.

Parent/Guardian signature required.

Please Circle Camp Attending: Maroon (July 4-7) Gold (July 9-12)

☐ Male ☐ Female

GENERAL INFORMATION

Name_____Date of Birth_____

Address_____City_____State____Zip_____

Name of Parent/Guardian_____

Home Phone_____Work Phone_____Cell Phone_____

Emergency Contacts (Cannot be listed as parent/guardian):

1._____Hm#_____Wk#_____Cell#_____

2._____Hm#_____Wk#_____Cell#_____

MEDICAL INFORMATION

Does your child suffer from any chronic or reoccurring condition or illness? If yes, please explain:

_____

All medication that is brought with the Camper **must** be in the original container with all labels intact and **must** be listed below. Prescription labels must have the Camper's name and current dosage. Dosage of non-prescription medication may not exceed product recommendation without doctor's written orders.

	Medication	Dosage	Frequency	Reason
1.				
2.				
3.				
4.				

Other Health Concerns (please attach explanations as needed):

Physical impairment restricting activities:	
Bone/joint injury in the past 12 months:	
Major illness in the past 12 months:	
Other:	
Please list any significant allergy:	

HEALTH CARE AND CAMP PERMISSION

Parent/guardian **must** initial and sign statements below

___ Medical care is available at your expense and this expense will not be assumed by the Camp or Texas State University. Doctors are available at the University Medical Center during the workday. I understand that in the event of serious illness or injury, Camp Administrators will seek professional medical attention including, but not limited to EMS transportation and hospitalization.

Medical Policy under which your child is covered including policy number (if applicable):

_____

I give permission for my child to be given the following medications according to the recommended dosage for age if necessary (please initial below):

____ Acetaminophen (Tylenol) ____ Ibuprofen (Advil) ____ Pepto-Bismol

____ Anti-Diarrhea (Imodium) ____ Antihistamine (Benadryl)

Parent or Guardian Signature: _____ Date: _____

Student Signature: _____ Date: _____