REDFERN HEALTH CENTER CLEMSON UNIVERSITY
SPECIAL GROUPS, SUMMER CAMPS, AND VISITORS ON CAMPUS

PLEASE PRINT: Complete all information where applicable.

Name of Camp or Special Event/Attending: _____

Participant's Name: _____
Last First Middle (Full)

Address: _____ Social Security No. ___/___/___
Street or Apt.

_____ Date of Birth _____

_____ Male _____ Female _____
Zip Code

Full Name of Parent/Guardian: _____

(Address, if different from above) _____

Home Telephone: (___) _____ Business Telephone: (___) _____

If not available in an emergency, notify: _____

Address: _____

Telephone: _____

PLEASE ATTACH COPY OF PRIVATE INSURANCE CARD

MEDICAL HISTORY
(To be completed by Parents or Self)

A. List all medications patient currently taking

_____

_____

B. List all medical conditions currently under treatment

_____

_____

C. Is patient allergic to any medications? Yes No
If yes, list

_____

_____

D. Date of last tetanus immunization _____

CONSENT FOR MEDICAL TREATMENT/RELEASE OF MEDICAL INFORMATION

I hereby give consent for any diagnostic, therapeutic, and/or operative procedures as may be deemed necessary by the provider of medical services. For minors, no major operative procedures will be performed, except emergency, without parent/guardian being contacted and fully informed.

I authorize the release of any medical information to process insurance claims and request payment of benefits to the physicians or supplier of services described.

I understand that any pre-existing illness or injury or reoccurrence of any pre-existing illness or injury will not be covered by the camp insurance and that the camp will assume responsibility only for injuries or illness incurred while the camper is participating in camp activities under supervision during the enrolled camp period, up to the limits of the purchased camp insurance.

I understand that should the camp insurance not cover the illness or injury, I will be responsible for payment in full or any charges incurred.

Signature of Participant _____
(Parent/Guardian Signature required for minors)

Date _____

FOR OFFICE USE ONLY

Preference for learning: ☐ Written Instruction ☐ Verbal Instruction ☐ Visual Instruction

Date	Time	Clinical Data