University of Michigan Summer Camp Health Questionnaire

(To be filled out by Participant's Parent or Guardian)

Participant: _____ **Birth date:** _____/_____/_____ **Sex:** M F

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

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

Parent/Guardian name(s): _____

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

Medication Name: _____ Dosage: _____ Directions: _____

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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?	☐	☐
2. been knocked out or unconscious?	☐	☐
3. had a seizure?	☐	☐
4. had a stinger, burner, or pinched nerve?	☐	☐
5. had any problems with his/her eyes or vision?	☐	☐
6. worn glasses, contacts or protective eyewear?	☐	☐
Circulation: Has the participant ever:		
7. been dizzy or passed out during or after exercise?	☐	☐
8. had chest pain during or after exercise?	☐	☐
9. tired out more quickly than their friends during exercise?	☐	☐
10. been told he/she has a heart murmur?	☐	☐
11. had racing heart or skipped heartbeats?	☐	☐
12. had anyone in their family died of heart problems or sudden death before age 50?	☐	☐
Respiratory:		
13. Does the participant ever have trouble breathing or cough during or after exercise?	☐	☐
Musculoskeletal:		
14. Does he/she frequently have heat or muscle cramps?	☐	☐
15. Does he/she use any special equipment (pads, braces, neck rolls, mouth guards, etc.)?	☐	☐
16. Has she/he had any injuries of any bones or joints?	☐	☐
☐ Head ☐ Chest ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle ☐ Neck ☐ Back ☐ Forearm ☐ Hand ☐ Thigh ☐ Calf ☐ Foot		
17. **Skin:** Does she/he have any skin problems (itching, rashes, acne, etc.)?	☐	☐
General:		
18. Has he/she ever had surgery or been hospitalized?	☐	☐
19. Has he/she had any other medical problems (infectious mono, diabetes, high blood pressure, etc.)?	☐	☐
20. Is he/she taking any medications or pills?	☐	☐
21. Does he/she have any allergies (medicines, bees or other stinging insects)?	☐	☐
22. When was the participant's last tetanus shot? _____		
23. When was the participant's last measles immunization? _____		

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: _____ **Date:** _____/_____/_____

HEALTH INSURANCE INFORMATION SHEET

EVERY PARTICIPANT MUST HAVE THIS FORM ON FILE

Private insurance information must be provided, if applicable. Please be advised that, should a participant require medical attention, **you are responsible for paying any costs not covered by insurance.**

Participant's Name: _____

Participant's Address: _____

Participant's Phone Number: _____

Date of Birth: _____

Insurance Company: _____ Effective Date: _____

Address of Insurance Company: _____

Phone Number of Insurance Company: _____ Group #: _____

Policyholder's Name: _____ Policy #: _____

Policyholder's Address: _____

Relationship to Participant: _____

Contract #: _____ Employee #: _____

I hereby authorize the release of any medical information which might be needed in connection with payment for medical services.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

I request that payment under my medical insurance program be made directly to the provider on any bills for services rendered by that provider. I understand that I am financially responsible for all costs not paid by my medical insurance program.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

EMERGENCY INFORMATION AND CONTACTS

Please complete this form in its entirety. This information will be helpful in the unlikely event of an accident or sudden illness.

Name of Personal Physician: _____ Phone: _____

Physician's Address: _____

Person(s) to be contacted in case of Emergency:

Name: _____ Relationship: _____
Address: _____
Daytime Phone: _____ Evening Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____
Address: _____
Daytime Phone: _____ Evening Phone: _____ Cell Phone: _____

State of Michigan Parent and Athlete Concussion Information

Michigan State Law requires operators of athletic activities for youth athletes to provide Sports Concussion Awareness Training through the following educational materials on the signs/symptoms and consequences of concussions to each youth athlete and their parents/guardians. Please sign below acknowledging receipt of the information. To learn more go to www.cdc.gov/concussion. (Content Source: CDC's Heads Up Program.)

WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion.

SYMPTOMS REPORTED BY ATHLETE:

- ✓ Headache or "pressure" in head
- ✓ Nausea or vomiting
- ✓ Balance problems or dizziness
- ✓ Double or blurry vision
- ✓ Sensitivity to light
- ✓ Sensitivity to noise
- ✓ Feeling sluggish, hazy, foggy, or groggy
- ✓ Concentration or memory problems
- ✓ Confusion
- ✓ Just not "feeling right" or is "feeling down"

SIGNS OBSERVED BY COACHING STAFF:

- ✓ Appears dazed or stunned
- ✓ Is confused about assignment or position
- ✓ Forgets an instruction
- ✓ Is unsure of game, score, or opponent
- ✓ Moves clumsily
- ✓ Answers questions slowly
- ✓ Loses consciousness (even briefly)
- ✓ Shows mood, behavior, or personality changes
- ✓ Can't recall events prior to hit or fall
- ✓ Can't recall events after hit or fall

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- ✓ One pupil larger than the other
- ✓ Is drowsy or cannot be awakened
- ✓ A headache that gets worse
- ✓ Weakness, numbness, or decreased coordination
- ✓ Repeated vomiting or nausea
- ✓ Slurred speech
- ✓ Convulsions or seizures
- ✓ Cannot recognize people or places
- ✓ Becomes increasingly confused, restless, or agitated
- ✓ Has unusual behavior
- ✓ Loses consciousness (even a brief loss of consciousness should be taken seriously)

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

2. Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

3. Remember: Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

Parent/Guardian Signature: _____ Date: _____

Participant Signature: _____ Date: _____

Parent/Guardian Consent, Medical Release and Release from Liability Agreement

Please read the following information carefully before signing.
All blanks must be completed.

Activity: _____ Activity Time Period: _____
Activity Sponsor: _____
Participant's Name: _____
Parent/Guardian's Name(s):_____

In consideration for allowing Participant to participate in Activity, I/we, as parents and/or guardians of Participant, agree to the following:

Authorize Participant to participate in the Activity for the Activity Time Period stated above.

Release, indemnify and hold harmless the Activity Sponsor and University from any and all damages, except for damages caused by the sole gross negligence or intentional misconduct of Activity Sponsor or University, arising out of the participation of Participant in the Activity.

Prior to the commencement of the Activity, I/we were made aware of the nature of the Activity, had sufficient opportunity to inquire further, and understand the Activity has inherent risks and I/we and Participant assume, on behalf of Participant, all those inherent risks.

While participating in the Activity, Participant is subject to the policies, rules and regulations of the University and Activity Sponsor. Possession of fireworks, explosives, any weapon, illegal drugs or alcohol is prohibited and cause for immediate expulsion from the Activity. Further, any Participant repeatedly disobeying University or Activity Sponsor policies, rules or regulations may be expelled from the Activity.

Authorize Activity Sponsor, its employees, clinicians, trainers, nurses and agents (collectively, "Activity Sponsor") the authority to seek, obtain, and approve any medical care and treatment including, but not limited to x-ray examination, anesthetic, medical, dental or surgical diagnosis, or treatment and medical care which may be recommended and provided under the general supervision of any physician or surgeon, for Participant which, in their judgment, is necessary for the health and well-being of Participant during his/her participation in the Activity. I/We further agree that I/we are(am) solely responsible for any costs incurred and agree to hold the Activity Sponsor and the Regents of the University of Michigan, their employees and agents (collectively, "University") harmless for any liability arising out of any good faith action taken in obtaining medical treatment for Participant.

The above agreements are binding upon us, our estates, heirs, representatives and assigns.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Participant Signature: _____ Date: _____