Abraham Baldwin AGRICULTURAL COLLEGE
University System of Georgia TIFTON, GEORGIA

Allergies: _____
_____
_____
_____

# Summer Programs and Camps

## HEALTH HISTORY AND CONSENT FORM

**As required under University System Policy, this form must be completed and returned to Abraham Baldwin College before the student will be eligible for Program enrollment.**

**PART A – To be completed by the parent or guardian for the participant (Please Print)**

**Expected date of**
**Name** _____ **Program enrollment** _____
**Last** **First** **Middle/Maiden** **Semester/Year**
**Home Address** _____

**City, State, Zip** _____ **Telephone (_____)**_____

**Sex:** ☐ **Male** ☐ **Female**

**Date of Birth** _____ **Social Security Number**_____

**Home Physician** _____ **City, State** _____

**Physician's Telephone Number** _____

**PART C**

**Directions: Please complete this portion of the form completely and carefully. It is not necessary to consult a physician for this history. Answer all questions. Information supplied will become part of a Health Record at ABAC. It will be held in the strictest of confidence.**

### FAMILY HISTORY

**Father:** ☐ **Living** ☐ **Dead** **If so, cause of death:** _____
**Mother:** ☐ **Living** ☐ **Dead** **If so, cause of death:**_____
**Brothers & Sisters:** **Number** _____ **If any have died, cause(s) of death(s):** _____
_____

**Have any of your relatives had any of the following (check appropriate box)**

☐ **Diabetes** ☐ **Tuberculosis** ☐ **Cancer** ☐ **Kidney disease** ☐ **Heart disease/high blood pressure**

**HAVE YOU EVER HAD or do you now have any of the following (check appropriate box):**

| | | | |
|---|---|---|---|
| ☐ **Shortness of breath** | ☐ **Chicken Pox** | ☐ **Scarlet Fever** | ☐ **Head injury** |
| ☐ **Recurrent back pain** | ☐ **Jaundice** | ☐ **Tuberculosis** | ☐ **Rheumatic fever** |
| ☐ **Arthritis** | ☐ **Diabetes Mellitus** | ☐ **Chronic cough** | ☐ **Bleeding/Hemophilia** |
| ☐ **Hay fever** | ☐ **Asthma** | ☐ **Epilepsy or convulsions** | ☐ **Periods of unconsciousness** |
| ☐ **Ear, nose or throat trouble** | ☐ **Stomach, liver or intestinal trouble** | ☐ **Paralysis or weakness** | ☐ **Kidney stones or blood in urine** |
| ☐ **Infectious mononucleosis** | ☐ **High or low blood pressure** | ☐ **Measles** | ☐ **Rubella (German Measles)** |

☐ **Other, please specify:** _____
_____

**Have you received treatment or counseling for emotional problems within 5 years?** ☐ **Yes** ☐ **No** **(If yes, attach explanation)**
**Do you know any reason why you should not participate in physical activities?** ☐ **Yes** ☐ **No** **(If yes, attach explanation)**
**Has your physical activity been restricted during the past 5 years?** ☐ **Yes** ☐ **No** **(If yes, attach explanation)**
**Have you ever had an allergic reaction to the following (check only appropriate boxes, if any):**
☐ **Penicillin** ☐ **Sulfa** ☐ **Eggs or Chicken** ☐ **Bee Stings** ☐ **Other, please specify:** _____
**Do you take any medication on a regular basis prescribed by your physician?** ☐ **Yes** ☐ **No** **(If yes, list below)**

| Name of Drug | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |

**PERMISSION FOR DIAGNOSTIC AND TREATMENT PROCEDURES:**

**If you are under 18 years of age, your parent or legal guardian must sign below in the space designated. If you are 18 or older, your signature alone will suffice.**

**I hereby authorize the ABAC Student Health Center, its agents or consultants, to perform diagnostic and treatment procedures on the program participant named above. I waive all claims to prior notification. If, in the judgment of the professional staff, the student's parents or guardians should be notified, this will be done.**

**SIGNATURES**

**Student (if 18 year or older)** _____ **Date** _____

**Parent/Guardians 1.** _____ **Date** _____

**2.** _____ **Date** _____

**PERSONS TO NOTIFY IN EMERGENCY: List below persons who may be notified in the event of an emergency.**

**1. Name** _____ **Relationship** _____

**Address** _____ **Telephone (_____)**_____

**2. Name** _____ **Relationship**_____

**Address** _____ **Telephone (_____)**_____