COMPLETE AND RETURN TO:

Brooks Health Center
300 College Street NE
Post Office Box 7178
Orangeburg, South Carolina 29117
Phone: 803-536-7053 Fax: 803-533-3747
BHC@scsu.edu

Health History and Physical Examination
SC State University

"Where Good Health Comes First"

Program: SC State MS/HS Summer Band Camp 2024

Print Name: Last ______ First ______ Middle ______

Date of Birth: ______ Age: ______ **Sex: Female / Male** (circle)

Home Address: ______ Phone: ______

Parent/Guardian: ______ Telephone: **Home #** ______

Work # ______ **Cell #** ______

Emergency Contact Person: Name: ______ Telephone: ______

Work # ______ **Cell #** ______

Name of Person Carrying Insurance: ______ Policy No. ______

Insurance Company Address/Telephone: ______

Student and Family Health History (To be completed by Student/Parents)

(√ or x for yes) for Illness or Disease	Student	Family	Comments/Explanations
Cardiovascular/Heart	☐	☐	
Hypertension	☐	☐	
Stroke	☐	☐	
Diabetes	☐	☐	
Arthritis	☐	☐	
Lung (+) TB Test/Chest X-ray/Chronic Bronchitis/ **Asthma**	☐	☐	
Kidney/Recurrent Urinary Problems	☐	☐	
Gastrointestinal	☐	☐	
Liver	☐	☐	
Neurological	☐	☐	
Emotional or Mental Illness/ Retardation	☐	☐	
Surgery/Hospital/Emergency Room	☐	☐	
OB/GYN: Date of last Menstrual Period	☐	☐	
Vision Loss/Eye Disease (Glasses/Contacts)	☐	☐	
Migraines/Vascular Headaches	☐	☐	
Sinusitis	☐	☐	
Anemia/SSD/SC/Thal/Traits	☐	☐	
Cancer/Immunodeficiency Disorder	☐	☐	
Rheumatic Fever	☐	☐	
Seizure/Convulsion	☐	☐	
Accidents/Injuries	☐	☐	
Drug/Alcohol/Tobacco Use/Abuse	☐	☐	
STD's/GC, Chlamydia, NGU, other	☐	☐	
Dental Caries, Gum Disease	☐	☐	
Eating Disorder	☐	☐	
Other/Explain	☐	☐	
Allergies **(LIST: Food/Medications/Environmental)**	☐	☐	

Continued on Back >>

Cont'd

Name: _____ Date of Birth _____ Sex: Female / Male (circle)

List all medication that you are currently taking (prescription and/or non-prescription)

Name _____Use_____ Dosage_____
Name _____Use_____ Dosage_____
Name _____Use_____ Dosage_____

Please list any medical concerns or conditions that we should know about not included above:

_____

_____

_____

Date of Last Tetanus Booster: _____

Primary Family Physician: _____

Address: _____

Telephone Number: _____

I, certify that the above information is **TRUE,** and the individual named is in good health and able to participate in all activities at SC State University unless indicated above.

I understand that **NO** physician is available on campus at SC State University-Brooks Health Center during the weekends/summer, however **professional nurses** are available. I hereby give permission for professional nursing assessment and limited treatment based on standing orders for minor illnesses and/or injuries. Any emergency illnesses/injuries will be referred to the **local health care facility** for further care/treatment with **all** expenses incurred payable by the parent/guardian.

I, further authorize any medical information to be released to off campus medical providers should it become necessary.

Signature of Parent/Guardian: _____Date: _____