

SC State UNIVERSITY

Division of Student Affairs

Summer and Evening
Camps
for the entire family
June 1 – July 31, 2009

DAY CAMP PROGRAMS

9:00 a.m. - 3:30 p.m.

- Basketball
- Bowling
- Cheerleading
- Chess
- Creative and Written Expressions
- Golf
- Soccer
- Swimming
- Tennis

EVENING CAMP PROGRAMS

5:30 p.m. - 9:30 p.m.

- Bowling
- Bridge
- Chess
- Line Dancing
- Mind-Body Fitness

For more information, contact:

Mrs. Marilyn Scott

(803) 536-8106

Visit our website:
www.scsu.edu



SC State University Division of Student Affairs

Summer Camp for the Entire Family 2009

Day Camp Application

Social Security No. _____ - _____ - _____ Date of Birth _____
(MM/DD/YY)

Name _____
Last First Middle

Mailing Address _____
Street, P.O. Box, etc.

City State Zip Code County or Province Country of Citizenship

Tel. Number _____ Cell Number _____ E-Mail Address _____

Father _____
Name Address

Mother _____
Name Address

Legal Guardian _____
Name Address

Did either parent attend SC STATE? Father: Yes _____ No _____ Mother: Yes _____ No _____

Highest degree or grade completed by parents. Father _____ Mother _____

Provide information for each elementary, middle or high school beginning with the most current.

Name of Elementary, Middle or High School	City	State	Dates Attended

List Activities: Community, church, athletics, dramatics, publications, music, art, and important offices held. List prizes, awards, and honors received.

HOW DID YOU LEARN ABOUT OUR SUMMER PROGRAM?

- ___ **AD** ___ **Church** ___ **Community Organization**
___ **SC State University Personnel** ___ **Friend** ___ **Family Member Referral**
___ **Campus Visit** ___ **Alumni Referral** ___ **Other** _____

Do you wish to request special admission consideration and accommodation based upon a disability: Yes ___ No ___
(If yes, attach an explanation.) List any educational or medical accommodation(s) you require.

Requested For Reporting Purposes Only

Gender:

Female _____

Male _____

Race or Ethnic Group:

African American/Black _____ Caucasian _____

American Indian/Alaskan Native _____ Asian or Pacific Islander _____

Hispanic _____ Other (specify) _____

SC State University does not discriminate on the basis of race, color, national origin, sex, disability, or age in its programs and activities.

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

**Division of Student Affairs
Summer Camp: 2009**



**Health History and Physical Examination
SC State University**

Please indicate enrollment status

- 9 to 15 youth 16 to 19 young adults
 20 to 35 adults 36 or over mature adults

“Good Health Comes First”

Print Name: Last _____ First _____ Middle _____

Date of Birth: _____ Age: _____ Sex: **Female / Male**

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	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Lung (+) TB Test/Chest X-ray/Chronic Bronchitis/ Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney/Recurrent Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	
Liver	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional or Mental Illness/ Retardation	<input type="checkbox"/>	<input type="checkbox"/>	
Surgery/Hospital/Emergency Room	<input type="checkbox"/>	<input type="checkbox"/>	
OB/GYN: Date of last Menstrual Period	<input type="checkbox"/>	<input type="checkbox"/>	
Vision Loss/Eye Disease (Glasses/Contacts)	<input type="checkbox"/>	<input type="checkbox"/>	
Migraines/Vascular Headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia/SSD/SC/Thal/Traits	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer/Immunodeficiency Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Seizure/Convulsion	<input type="checkbox"/>	<input type="checkbox"/>	
Accidents/Injuries	<input type="checkbox"/>	<input type="checkbox"/>	
Drug/Alcohol/Tobacco Use/Abuse	<input type="checkbox"/>	<input type="checkbox"/>	
STDs/GC, Chlamydia, NGU, other	<input type="checkbox"/>	<input type="checkbox"/>	
Dental Caries, Gum Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Other/Explain	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies (LIST: Food/Medications/Environmental)	<input type="checkbox"/>	<input type="checkbox"/>	

Continued on Back

Cont'd

Name: _____ Date of Birth _____ Sex: Female / Male

List all medication that you are currently taking

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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 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 Regional Medical Center 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/Self: _____ Date: _____