Student Name: FIRST _____ LAST _____

STUDENT MEDICAL FORM

Illinois Summer Youth Music
University of Illinois
1114 West Nevada St., Urbana, IL 61801
(217) 244-3404 | isym@illinois.edu

SESSION 1: June 22-27 ☐
SESSION 2: July 6-11 ☐
SESSION 2: July 13-18 ☐

Submit this form at least two weeks prior to the first day of camp.
*ISYM does **not** require a physician's signature on the Student Medical Form, nor is a physical exam required.*

STUDENT

First Name: _____ Last Name:_____

Student Age: _____ Birth Date: ___/___/_____ Student Cell: (_____)_____

PARENT OR GUARDIAN (PRIMARY CONTACT)

First Name: _____ Last Name:_____ Relationship to student: _____

Address: _____City: _____State: _____Zip Code: _____

Phone No 1: (_____)_____ Phone No. 2: (_____)_____

Email: _____

ADDITIONAL EMERGENCY CONTACTS – (In case parent/guardian cannot be reached)

First Name: _____Last Name:_____Relationship to student: _____
Phone No 1: (_____)_____ Phone No. 2: (_____)_____

Email: _____

First Name: _____Last Name:_____Relationship to student: _____
Phone No 1: (_____)_____ Phone No. 2: (_____)_____

Email: _____

INSURANCE PROVIDER/FAMILY PHYSICIAN

Insurance Provider: _____ Insurance Policy Number: _____

Primary Care Physician: _____ Phone Number: (_____)_____

STUDENT MEDICAL HISTORY - Check the box before any of the diseases or neurodivergent conditions the student has had.

☐ Asthma	☐ Depression	☐ Covid-19	☐ Diabetes	☐ Chicken Pox
☐ Diphtheria	☐ Epilepsy, convulsions	☐ Hay fever	☐ Heart disease	☐ Lung disease
☐ Anxiety	☐ Dyslexia	☐ Measles	☐ Measles (3-day)	☐ Tourette Syndrome
☐ ADHD	☐ Dysgraphia	☐ Poliomyelitis	☐ Scarlet fever	☐ Hernia (rupture)
☐ Autism Spectrum	☐ Typhoid fever	☐ Whooping cough	☐ Small pox	☐ Other _____

NON-FOOD ALLERGIES: _____

FOOD ALLERGY – ☐ Yes ☐ No
If yes, please also complete the Food Allergies_Intolerances_Dietary Accomodations Form for the dining hall.

Student Name: FIRST _____ LAST _____

MEDICATION INFORMATION/STUDENT HEALTHCARE MONITORING

Does the student carry emergency medication with them? ☐ Yes, please list: _____

Does the student have an IEP (Individaulized Education Program) or need additional support services?

□ Yes □ No If yes, please specify needs: _____

List all medications taken regularly and specify the purpose and schedule for taking such medication: _____

_____

List medications taken only as needed: _____

Is student allergic to any medications? ☐ Yes ☐ No If yes, please list: _____

_____

Is student capable of reasonable physical activity (athletics, strenuous activity)? ☐ Yes ☐ No

If no, state reason and limitations: _____

Please list any other pre-existing medical conditions or risks that the counseling staff should be aware of:

_____

I authorize the ISYM counseling staff to administer the following over-the-counter medications in the event that a parent/guardian can't be reached.

☐ Tylenol ☐ Advil ☐ Benadryl ☐ Pepto Bismol ☐ Other _____

_____

CONSENT

By participating in the camp, the participant agrees to comply with all ISYM rules, procedures, and guidelines, including but not limited to rules, procedures, and guidelines related to communicable diseases. In the event that the student exhibits symptoms of a communicable disease or is identified as a close contact, I, the undersigned parent or guardian, understand and consent to the following policies and procedures:

Persons who develop symptoms of a communicable disease during the camp will be assessed by an appropriately trained member of the camp staff as follows:

- ISYM staff will evaluate symptoms and check the temperature of the individual according to camp processes using an appropriate thermometer of choice.
- ISYM participants with a fever will be placed in isolation until they can return home. They must remain home until they are fever and symptom-free for 24 hours without use of fever-reducing medications and may only return with approval from ISYM Administration.
- If the individual does not have a fever, but has two or more symptoms of a communicable disease, they will be placed in isolation from other participants and staff members.

In an emergency, if the parent/guardian or one of the additional emergency contacts cannot be reached, I authorize ISYM to make provision for treatment with the appropriate medical personnel or facility.

I certify that every answer that I have given on this form is complete and accurate to the best of my knowledge. I understand that answers to these questions are of vital importance to my child's health care while at ISYM.

_____ _____

Parent or Legal Guardian Signature **Date**

By typing my name above, I understand and agree that this form of electronic signature has the same legal force and effect as a manual signature.