4-H CAMP COUNSELOR HEALTH/RELEASE FORM

THIS FORM MUST BE ON FILE FOR YOU TO ATTEND CAMP!

RETURN TO: CATHY BOERSTE, RANDY BROWN, OR CHEVEN MAY

CAMP DATES: JUNE 6-8, 2008

County ________________________

Name ____ Date of Birth ________________________

Address____
Route or street City State Zip code

Age ______ Gender: Circle M or F RACE* ___________*Necessary to comply with affirmative action -- Civil Rights Standard

Have you attended 4-H Camp before? Yes ________ No ________ For how many years? ________________________

School attended ______________________________ Grade in School as of May 1 of Current Year_______________

Custodial parent/guardian______________________________ Phone: ____________________ Cell: _____________________

Home address____
Route or street City State Zip code

Second parent/guardian/emergency contact ____Cell: _____________________

Address____ Phone: _________________________
Route or street City State Zip code

If neither is available in an emergency, please notify:

Name ____

Relationship ____ Phone: ______________________

Address ____ Cell: ________________________

Route or street City State Zip code

Important – This box must be complete for attendance!

Parent/Guardian Authorizations: this health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed and over the counter medications, and seek emergency medical treatment including ordering x-rays and routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian ____

Printed Name of parent/guardian Date

Photo Use Permission

I grant the Kentucky 4-H Program, the University of Kentucky, Purdue Extension, and persons acting through them, the right to use, reproduce, assign and/or distribute photographs, films, videotapes and sound recordings of myself or my minor child without compensation for use in promotion/advertising, educational publications or electronic publishing (web sites) which they may create. Children's names will not be published.

Signature of parent/guardian ____Date __________________

Printed Name of parent/guardian Date

PHOTOCOPY (FRONT & BACK) OF HEALTH INSURANCE CARD MUST BE ATTACHED TO THIS FORM!!!

Insurance Information

Is the participant covered by family medical/hospital insurance? [ ] Yes [ ] No

If so, indicate carrier or plan name: ____ Group # _________________________

General Questions (Explain "yes" answers below.) Disabilities accommodated with prior notification.

Has/does the participant:	Yes	No
1. Had any recent injury, illness or infectious disease?	[ ]	[ ]
2. Have a chronic or recurring illness/condition?	[ ]	[ ]
3. Ever been hospitalized?	[ ]	[ ]
4. Ever had surgery?	[ ]	[ ]
5. Have frequent headaches?	[ ]	[ ]
6. Ever had a head injury?	[ ]	[ ]
7. Ever been knocked unconscious?	[ ]	[ ]
8. Wear glasses, contacts or protective eye wear?	[ ]	[ ]
9. Ever had frequent ear infections?	[ ]	[ ]
10. Ever passed out during or after exercise?	[ ]	[ ]
11. Ever been dizzy during or after exercise?	[ ]	[ ]
12. Ever had seizures?	[ ]	[ ]
13. Ever had chest pain during or after exercise?	[ ]	[ ]
14. Ever had high blood pressure?	[ ]	[ ]
15. Ever been diagnosed with a heart murmur?	[ ]	[ ]
16. Ever had back problems?	[ ]	[ ]
17. Ever had problems with joints (e.g., knees, ankles)?	[ ]	[ ]
18. Have an orthodontic appliance being brought to camp?	[ ]	[ ]
19. Have any skin problems (e.g., itching, rash, acne)?	[ ]	[ ]
20. Have diabetes?	[ ]	[ ]
21. Have asthma?	[ ]	[ ]
22. Had mononucleosis in the past 12 months?	[ ]	[ ]
23. Had problems with diarrhea/constipation?	[ ]	[ ]
24. Had problems with sleepwalking?	[ ]	[ ]
25. If female, have an abnormal menstrual history?	[ ]	[ ]
26. Have a history of bed-wetting?	[ ]	[ ]
27. Ever had an eating disorder?	[ ]	[ ]
28. Ever had emotional difficulties for which professional help was sought?	[ ]	[ ]

Please explain any 'yes' answers, noting the number of the questions.

____

____

Which of the following has the participant had?	Please give all dates of immunization for: Vaccine:	Dates: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
[ ] Measles	DTP	_____	_____	_____	______	_____	_____
[ ] Chicken Pox	TD (tetanus/diphtheria)	_____	_____	_____	______	_____	_____
[ ] German measles	Tetanus	_____	_____	_____	______	_____	_____
[ ] Mumps	Polio	_____	_____	_____	______	_____	_____
[ ] Hepatitis A	MMR	_____	_____				
[ ] Hepatitis B	or Measles	_____	_____				
[ ] Hepatitis C	or Mumps	_____	_____				
	or Rubella	_____	_____				
TB Mantoux Test	Haemophilus influenza B	_____	_____	_____	______		
Date of last test________	Hepatitis B	_____	_____	_____			
Result [ ] Positive [ ] Negative	Varicella (chicken pox)	_____					

Use this space to provide additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.____

____

Name of family physician ____ Phone ______________________

Address ____

Name of family dentist/orthodontist_____________________________________ Phone ______________________

Address ____

HEALTH HISTORY

The following information must be filled in by the parent/guardian. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES

Medications allergies (list) Describe reaction and management of the reaction.

________________________ ____

________________________ ____

Food allergies (list) Describe reaction and management of the reaction.

________________________ ____

________________________ ____

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc. Describe reaction and management of the reaction.

_______________________ ____

_______________________ ____

Please list any **DIETARY RESTRICTIONS**

that apply to this individual.____

4-H CAMP HEALTH FORM
(Youth)

____________________________________ ____

County Camp Counselor's Name

List any activities the participant should avoid (i.e., swimming):
____

Physical Record of Participant:	**Check**	**Yes**	**OR**	**No**
Heart Condition		___		___
Diabetes		___		___
Ear Infections		___		___
Bedwetting		___		___
Allergy to any medication		___		___

List medicines allergic to: _________________________________

Other allergies (i.e., food, dust, pollen, animals)		___		___

List other allergies _______________________________________

Date of last tetanus shot: __________________________________

Please list any current medication being taken: ____
____
____

Any other medical record information that would be beneficial during the program or in an emergency:
____
____
____
____

PARENTAL AUTHORIZATION

Pursuant to Indiana Code Paragraph 16-36-1-6 and subject to any limitations listed below, I request and authorize Purdue University Cooperative Extension Service employees and their authorized agents to arrange for all reasonably necessary medical care, including transportation and hospitalization, for my child while in attendance at and participating in 4-H Youth Development events and activities.

I also understand that, as a result of my child's participation in this program, it will be necessary for Purdue CES employees and other authorized personnel with the program to have access to relevant medical information pertaining to my child, and I authorize the use and disclosure of my child's medical information to promote a safe and healthy experience for my child.

___________________________________ ____

Parent/Legal Guardian Signature Date Witness to Parent/Legal Guardian Date

Parent/Guardian Telephone:

(______)______________________ (______)_________________________

Home Work

In case we cannot reach you, please list the name and phone number of a second party to contact:

Name ____

Address ____

Telephone: (_____)________________________________ (______)_____________________________________

Home Work

Kentucky 4-H Camps
Camper Medication Form

All Prescription Medications Must Be In Its original Container.

Name: ____ **Age:** _______ **Weight:** ________

Medication/Rx Number: ______________________ **Amount:** _______ **mg/cc Medication Name:** ________________

Number of tablets/pills/capsules/etc. sent to camp: _______________

Check the correct statement:
___ **This medication is properly contained in its original container and should be used as directed.**
___ **This is a non-prescription medication. If you check this statement, you must complete the box below!**

Circle all that apply

To be taken at: Breakfast Lunch Mid-afternoon Supper Bedtime As Needed

Directions and warnings (please be specific):
____
____
____

Medication/Rx Number: ______________________ **Amount:** _______ **mg/cc Medication Name:** ________________

Number of tablets/pills/capsules/etc. sent to camp: _______________

Check the correct statement:
___ **This medication is properly contained in its original container and should be sued as directed.**
___ **This is a non-prescription medication. If you check this statement, you must complete the box below!**

Circle all that apply:

To be taken at: Breakfast Lunch Mid-afternoon Supper Bedtime As Needed

Directions and warnings (please be specific):
____
____
____

Parent Declaration

I, ______________________________________, as the parent or legal guardian of ____, understand that the Camp Emergency Medical technician shall act as the designee of the Camp to see that my child takes his/her medication as it is prescribed or as directed above. In the even that my directions differ from those on the original container, I understand that I must obtain a note from the prescribing physician confirming the directions that should be followed in administering medications to my child. Furthermore, I understand that if there are any questions or concerns, I may be contacted.

____ ______________________________________
Signature of Parent/Legal Guardian Date