

MEDICAL INFORMATION FOR YOUTH PARTICIPANTS



INSTRUCTIONS: Complete the entire form and bring with you to 2009 4-H Electric Camp.

District _____ County _____ Program Date _____

Camper's Name _____ Male _____ Female _____

FIRST LAST

Address _____ Date of Birth _____ Age(while at camp) _____

City _____ State _____ Zip _____ **Camper's Social Security NO.*** _____ - _____ - _____

Parent or Guardian Name _____ **Daytime Phone** (____) _____

Address _____ **Evening Phone** (____) _____

City _____ State _____ Zip _____ **Cell Phone** (____) _____

EMERGENCY CONTACTS: (if parent or guardian cannot be reached)

Name _____ Daytime Phone (____) _____ Evening Phone (____) _____

Name _____ Daytime Phone (____) _____ Evening Phone (____) _____

Name of Family Physician: _____ Phone: (____) _____

Medical Insurance Carrier: _____ Policy Number: _____

ACTIVITY RESTRICTIONS:

Is there any reason to restrict full activity, including hiking, swimming or other strenuous play? ____ Yes ____ No

IF YES, describe in detail: _____

_____ (Use a separate page if needed.)

MEDICATIONS: - Please list **ALL** medications, including over-the-counter or nonprescription drugs and supplements. Send enough medication to last the entire time at camp. Keep all medications in the original packaging or bottle that identifies the prescribing physician, name of medication, dosage and frequency. Use an additional sheet if necessary.

Med # 1 name _____ reason for taking _____

Med # 2 name _____ reason for taking _____

Med # 3 name _____ reason for taking _____

Med # 4 name _____ reason for taking _____

MEDICATION ALLERGIES: - Please list **ALL** medications, including over-the-counter or nonprescription drugs and supplements your child is allergic to. Use an additional sheet if necessary.

Med # 1 name _____ Med # 2 name _____

Med # 3 name _____ Med # 4 name _____

PLEASE CHECK "over-the-counter" medication(s) which camp personnel may administer as deemed necessary:

____ Acetaminophen (Tylenol) ____ Ibuprofen (Motrin) ____ Pepto Bismol ____ Roloids
____ Neosporin/Cortisone cream ____ Robitussin ____ Benadryl ____ Immodium AD
____ Calamine / Caladryl ____ **Any As Needed**

NO, DO NOT ADMINISTER ANY "over-the-counter" medications to my child.

____ **PLEASE INITIAL.**

*medical facilities may require SSN to provide treatment

IMMUNIZATION HISTORY (MANDATORY) Please give **DATE OF LATEST IMMUNIZATION** for:

_____ Tetanus _____ Haemophilus influenza B _____ Varicella (chicken pox)
_____ Diphtheria _____ TB Mantoux Test - Result: ___ Positive ___ Negative
_____ Mumps _____ DTP _____ Polio _____ Hepatitis B _____ Small Pox

HEALTH HISTORY: (Please check any of the following that apply)

_____ Frequent Ear Infections _____ Heart Defect / Disease
_____ Convulsions _____ Diabetes: ___ Type I (juvenile) ___ Type II
_____ Hypoglycemia _____ Bleeding/Clotting Disorders
_____ Other _____

ALLERGIES: (Please Check any of the following that apply)

___ Hay Fever ___ Poison Ivy/Oak ___ Insect Stings ___ Other (please list) _____

OPERATIONS OR SERIOUS INJURIES: (List along with approximate date): _____

CHRONIC OR RECURRING ILLNESS: _____

ANY OTHER INFORMATION: _____

PLEASE ATTACH AN ADDITIONAL SHEET if necessary to provide any **additional medical information** or additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware.

___ **ADDITIONAL INFORMATION ATTACHED** ___ **NO ADDITIONAL INFORMATION**

PERMISSION TO PROVIDE NECESSARY TREATMENT OR EMERGENCY CARE

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

_____ **Parent or Guardian Signature** _____ **Date**