MEDICAL INFORMATION FOR YOUTH PARTICIPANTS

INSTRUCTIONS: Complete the entire form and bring with you to the District 2 4-H __________ Junior Leader Lab.

District ________ County _________________________ Camp Date: __________ **to** __________

Camper's Name ____________________ _______________________________ Male ☐ Female ☐
FIRST LAST

Address ____ Date of Birth ______________

City ________________________________ State _____ Zip ___________ Age (while at camp) ________

Parent or Guardian Name __________________________________ **Daytime Phone** ______________________

Address ____ **Evening Phone** ______________________

City ____________________________ State _____ Zip ____________ **Cell Phone** ______________________

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

Name ______________________ Day Phone ______________________ Evening Phone ______________________

Name ______________________ Day Phone ______________________ Evening Phone ______________________

Name of Family Physician: ____ Phone ______________________

Medical Insurance Carrier: ____ Policy #: ______________________

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 an additional page if necessary.)

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.

Name of Medication	Reason for Taking
1.	
2.	
3.	
4.	

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

Name of Medication	Name of Medication
1.	3.
2.	4.

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

- ☐ Acetaminophen (Tylenol)
- ☐ Ibuprofen (Motrin)
- ☐ Pepto Bismol
- ☐ Rolaids
- ☐ 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**

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

_____________ Tetanus _____________ Haemophilus influenza B _____________ Varicella (chicken pox)
_____________ Diphtheria _____________ Mumps _____________ DTP
_____________ Polio _____________ Hepatitis B _____________Small Pox
_____________ TB Mantoux Test - Result: ☐ Positive ☐ Negative

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

☐ Convulsions ☐ Diabetes: ☐ Type I (juvenile) ☐ Type II
☐ Frequent Ear Infections ☐ Hypoglycemia
☐ Heart Defect / Disease ☐ 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**