



# 4-H CAMP HEALTH FORM YOUTH CAMPER/COUNSELOR/ADULTS

**DUE: June 30<sup>TH</sup> with  
Registration Form**

County \_\_\_\_\_

Camper's Name \_\_\_\_\_

Sex: M  F  Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_



Parent/Guardian Name \_\_\_\_\_

Home Phone \_\_\_\_\_

Mother's Cell Phone #: \_\_\_\_\_

Father's Cell Phone #: \_\_\_\_\_

Mother's Work Phone #: \_\_\_\_\_

Father's Work Phone #: \_\_\_\_\_

Name of Family Physician: \_\_\_\_\_

Phone #: \_\_\_\_\_

Family medical/hospital insurance carrier: \_\_\_\_\_

Policy or Group #: \_\_\_\_\_

**Please include a copy of your primary insurance card (front and back).**

**PART I: Illnesses and injuries** (Check those that apply and give appropriate dates.)

- Diabetes
- Ear Infection, Strep throat
- Heart Defect/Disease
- Hypertension
- Bleeding/Clotting Disorders
- Seizures
- Asthma
- Asthma medications/inhalers (please describe) \_\_\_\_\_

\*If inhaler must be carried by child during camp, camper must have a fanny pack to carry it.

Date of last health examination \_\_\_\_\_

Were any medical problems noted in last health examination? \_\_\_\_\_

**If child takes routine medications and will be taking them while at camp, please list below.**

Medication	Dosage	Medication	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**I UNDERSTAND IT IS A STATE LAW THAT ALL MEDICATIONS MUST BE LOCKED AND GIVEN TO THE CAMP NURSE FOR DISTRIBUTION AT CAMP. ALL MEDICATIONS MUST BE CHECKED IN WHEN BOARDING THE BUS. IT IS MY RESPONSIBILITY AS A PARENT/GUARDIAN TO SEND THE MEDICATION IN THE ORIGINAL PHARMACY CONTAINER. PLEASE PLACE ALL MEDICATIONS IN ZIP LOCK BAG.**

**PART II: Allergies** (Check those that apply and specify nature of allergic reaction.) **Describe allergic reaction here:**

- Animals \_\_\_\_\_
- Hay Fever \_\_\_\_\_
- Pollen \_\_\_\_\_
- Food \_\_\_\_\_
- Medicines/drugs \_\_\_\_\_
- Insect stings \_\_\_\_\_
- Plants \_\_\_\_\_
- Other (specify) \_\_\_\_\_

**\*If allergic to bee stings, it is mandatory to provide bee sting kit for camper.**

**PART III: Other health conditions** (check those that apply) **PART IV: Immunization History DATES REQUIRED**

- Bed wetting
- Constipation
- Menstrual cramps
- Motion sickness
- Nosebleeds
- Sleep disturbances
- Sleep walking
- Fear of water
- Other (specify): \_\_\_\_\_
- Emotional disturbances
- Fainting
- Hearing impairment
- Sickle cell trait or disease
- Special dietary regimen
- Wear glasses/contact lenses
- ADD/ADHD
- Fear of darkness

DTP	OVP (polio)	MMR
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	
4. _____	4. _____	
<b>Hepatitis</b>	<b>TB Booster*:</b>	
1. _____	_____	
2. _____		

\*A Tetanus Booster is recommended to be given between the ages of 11-12 and then every ten years thereafter.

If the R.N. or Designated First Aid person feels it is appropriate, could your child be given: Acetaminophen (Tylenol)  Yes  No  
Ibuprofen (Advil)  Yes  No

Camper's Weight \_\_\_\_\_ Camper's Height \_\_\_\_\_ (weight needed to determine medication dosage) **OVER**

