4-H CAMP HEALTH FORM

YOUTH CAMPER/COUNSELOR/ADULTS

DUE: June 15TH with Registration Form

County______Kenosha_______________

Camper's Name________________________________ Sex: M☐ F☐ Birth date____/____/____

Parent/Guardian Name____________________________ Home Phone_____________ Work Phone:__________

Mother's Cell phone #:___________________________ Father's Cell phone #:____________________________

Name of Family Physician:_______________________________ Phone #:______________________________

Family medical/hospital insurance carrier:_________________________ Policy or Group #:___________________

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___________________
☐Pollen____________________
☐Medicines/drugs___________
☐Plants____________________
☐Hay Fever_________________
☐Food______________________
☐Insect stings_____________
☐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)

☐Bed wetting
☐Constipation
☐Menstrual cramps
☐Motion sickness
☐Nosebleeds
☐Sleep disturbances
☐Sleep walking
☐Fear of water
☐Emotional disturbances
☐Fainting
☐Hearing impairment
☐Sickle cell trait or disease
☐Special dietary regimen
☐Wear glasses/contact lenses
☐ADD/ADHD
☐Fear of darkness

Other (specify):____

PART IV: Immunization History DATES REQUIRED

DTP	OVP (polio)	MMR
1.__________	1.__________	1.__________
2.__________	2.__________	2.__________
3.__________	3.__________	
4.__________	4.__________	

Hepatitis
1.__________
2.__________

TB Booster*:____________________

*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

ART V: Camp Activities

The following activities are part of the camp program. Please (X) those that your child CAN NOT participate in:

Swimming	☐	Canoeing/Boating	☐	Archery	☐	Hiking	☐
General Sports	☐	Challenge Course	☐	Tae Kwon Do	☐	Other ______________________________	

Please explain any health conditions, activity restrictions of other information useful to the camp staff.

Does this youth require a special accommodation to participate in any of the described activities? ____Yes ____No
If yes, please describe the accommodation that is needed.

This health history is correct as far as I know, and my son/daughter/ward has my permission to engage in all prescribed activities, except as noted by me and the physician. In the event of a serious injury or illness, I will be notified. If I cannot be reached in an emergency, I hereby give my permission to the physician to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my son/daughter/ward. I also agree not to hold Camp Timberlee, Racine, Jefferson or Kenosha County 4-H Camp, Kenosha County 4-H Council, Inc. and UW-EXTENSION responsible for any personal injury or accident while at camp.

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 or upon arrival. 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.

I understand that as the parent/guardian signing this form that I will be held financially responsible for any expenses above and beyond what the camp insurance will pay.

______________________________________ ______________________________
Signature of Parent/Guardian Date

Address: ______________________________________ Work Phone: ______________________

City: ______________________________________ State: Wisconsin Zip ________________

** If there is any change in my son/daughter's health condition within 2 weeks prior to camp (i.e., any surgery, illness, contagious skin rashes or a visit to the Emergency Room). I will notify the 4-H Youth Development Educator in my county and have written physician permission to be at camp.

*****IF PARENTS ARE NOT AVAILABLE IN CASE OF EMERGENCY, PLEASE NOTIFY:**

1. NAME: ______________________________ **PHONE:** ______________________

RELATIONSHIP TO CHILD ______________________________

2. NAME: ______________________________ **PHONE:** ______________________

RELATIONSHIP TO CHILD ______________________________

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