MEDICAL INFORMATION FOR YOUTH PARTICIPANTS

INSTRUCTIONS: Complete the entire form and return to your County Agent. This form will be turned in with any medication you bring, both prescription and non-prescription, to the health room upon your arrival. The information on this form is gathered only to assist us in identifying appropriate care for your child. Any changes to this form should be provided to the camp health care provider upon the participant's arrival in camp. Provide complete information so that we can be aware of your child's needs.

District _____ County_____ Program Date _____

Camper's Name _____ Male _____ Female _____
FIRST LAST

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

City _____ State _____ Zip_____

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 ____ 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 _____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**