

4-H CAMP CLIFTON HEALTH FORM

To be Completed by Parent or Guardian

Please Print in Ink or Type

Identification:

Name _____ Date of Birth _____ Camp Attending **Union County 4-H**

Home Address _____
(Street) (City) (Zip Code)

Age _____ Sex _____ School Grade Completed _____ Your County **Union**

Name of parent or guardian _____ Home Phone () _____.

Cell Phone () _____.

Name of person picking child up from camp _____ Phone () _____.

Emergency Information:

If unable to reach parent or guardian in the event of an emergency, please notify:

Name _____ Relationship _____ Phone () _____.

Name _____ Relationship _____ Phone () _____.

Name of personal physician _____ Phone () _____.

Name of personal dentist _____ Phone () _____.

Personal Health/Accident Insurance Carrier _____ Policy # _____.

Prescription Medications:

Is your child taking any medication regularly? ___ Yes ___ No If Yes, Describe:

If your child is taking a prescription medication regularly, plan to send the medication to camp. In the next camper letter there will be a form to send with the medication.

Over the Counter Medications

The camp health center will stock the over-the-counter medication listed below. These can be given to your child as needed, as determined by the camp nurse. If you have some other over-the-counter medication you feel your child may need, plan to send it to camp and give it to the nurse at check-in.

Please check all that are acceptable to give your child:

- | | |
|---|---|
| <input type="checkbox"/> Acetaminophen, Children's chewable | <input type="checkbox"/> Hydrocortisone cream |
| <input type="checkbox"/> Acetaminophen, Adult, age 12 plus | <input type="checkbox"/> Benadryl caplets |
| <input type="checkbox"/> Ibuprofen caplets, Jr. | <input type="checkbox"/> Calydryl lotion |
| <input type="checkbox"/> Antibiotic cream (such as Neosporin) | <input type="checkbox"/> Elixir antihistamine decongestant (such as Robotussin) |
| <input type="checkbox"/> Anti-diarrhea caplets (such as Pepto Bismol) | <input type="checkbox"/> Sunburn spray (such as solar cane) |

Immunizations:

Tetanus Toxoid: Date of Last Immunization or booster _____.

Are your childhood immunizations up to date? _____ Yes _____ No

Over....

Check if Participant is Subject To:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fainting | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Constipation | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Bleeding/Clotting Disorders |
| <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Athletes Foot | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Asthma Controlled: [] Yes [] No |
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Epileptic Seizures | <input type="checkbox"/> Home Sickness | <input type="checkbox"/> Other (Specify) _____. |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cramps | <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> Wears dental braces | <input type="checkbox"/> Wears Contact Lenses | | |

List any health conditions which have occurred within the last 12 months which might affect or restrict camp activities:

Participant is Allergic To:

Foods Specify) _____

Medications, Prescription or Non-Prescription Drugs (Specify) _____

Serious Ivy, Oak or Sumac Poisoning _____.

Bee or Insect Stings _____ Prescribed Treatment _____

Other _____

Parent/Guardian Medical Release

_____ has my permission to participate in the Ohio 4-H program and activities (with the exception of those restricted activities listed). I understand participants will be supervised. I understand that the staff and volunteers, Union County 4-H Camp, Ohio State University Extension and The Ohio State University are not responsible in the event of accidental injury or illness, nor for compounded injury or illness to the participant's present medical conditions listed. I further understand in case of serious injury or illness, I will be notified. If I cannot be contacted, I give my permission to the attending physician to hospitalize, secure proper treatment and to order injection, anesthesia, or surgery for the participant as named above. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. The camp nurse has my permission to administer the prescription medications and/or over-the-counter medications.

Signature of parent or guardian _____.

Date _____.