

4-H CAMP WABASSO



HEALTH FORM

NEW YORK STATE requires camps to have a completed health form on each child.

This form MUST be submitted no less than 1 week prior to the start of your child's camp experience.

Name _____ Birth date _____ Sex _____ Age _____
Last First

Parent or Guardian _____

Home Address _____ Phone _____
Number and Street City/State Zip Area/Number

Business _____ Phone _____
Number and Street City/State Zip Area/Number

Second Parent/Guardian, who may pick up your child: _____

Home Address _____ Phone _____
Number and Street City/State Zip Area/Number

Business _____ Phone _____
Number and Street City/State Zip Area/Number

In the event of an emergency, **and parent or guardian cannot be reached**, notify _____.

Relationship to camper: _____ Home Phone: _____

Home Address _____ Business Phone: _____
Number and Street City/State Zip

MEDICAL INSURANCE		<small>Your personal medical policy is your child's primary coverage. All registered campers are covered by excess coverage accident insurance while at camp.</small>	
Policy Holder's Name		Name of insurance carrier and type of coverage.	
Policy Number		Group Number	
Address of Insurance Company (Include street, city, state, and zip code)			

REQUIRED SIGNATURES

This health form is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted.

Authorization for treatment: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the medical personnel selected by the camp director to secure and administer treatment, including hospitalization, for my child, as named above. Further, we agree to abide by the restrictions noted by our physician on the back of this form.

We agree to abide by all policies and procedures contained within the handbook.

SIGNATURE OF PARENT OR GUARDIAN: _____

SIGNATURE OF CAMPER: _____

LAST NAME: _____

FIRST NAME: _____

AGE: _____

CAMP: Week 1 2 3 4 5 6

Resident, Day,

HEALTH HISTORY - TO BE COMPLETED BY PARENT/GUARDIAN

CAMPER NAME: _____

HEALTH HISTORY (Note approximate date of illness):

DISEASES:

ALLERGIES:

frequent ear infections bleeding/clotting disorders
 heart defect/disease hypertension
 epilepsy, seizures mononucleosis
 diabetes psychiatric treatment

Chicken pox
 Measles
 German Measles
 Mumps

Hay Fever ivy poisoning, etc.
 insect stings other drugs
 Penicillin Asthma
 Asthma Foods _____
 Latex Other _____

IMMUNIZATION HISTORY: Please record the date (month and year) of basic immunizations and recent boosters or include a copy of immunization records.

_____ Diphtheria _____ Pertussis (Whooping Cough)DPT _____ Tetanus or Tetanus TD _____ Diphtheria or Tetanus _____ Polio IPV _____ Haemophilious influenza b (HIB)	_____ Varicella (Chicken Pox) _____ Measles (Hard Measles, Red Measles, Rubella) _____ Mumps _____ Rubella (German Measles, 3-Day Measles) _____ Tuberculin Test Given _____ Hepatitis B
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Operations or serious injuries: _____

Disability or chronic/recurring illness: _____

Dietary modifications: _____

Name/Phone of dentist/orthodontist: _____

Name/Phone of physician : _____

Suggestions on health-related information: _____
 (Attach additional pages if necessary)

FOR FEMALE: Has this person menstruated? Yes No If not has she been told about it? Yes No
 If yes, is her menstrual history normal? Yes No Special Considerations: _____

MEDICATIONS: Please note that all medications must be given to the camp nurse upon arrival at camp, in the original container, with directions from the physician to dispense.

Medication	Instructions for use	Reason for use

TO BE COMPLETED BY A LICENSED PHYSICIAN

PHYSICAL EXAMINATION

DATE OF LAST PHYSICAL EXAM (MM/DD/YYYY) _____ (MUST BE WITHIN TWO YEARS OF CAMP ATTENDANCE)

General Condition or Appraisal

Height: _____	Ears: _____	Menstruation: _____
Weight: _____	Nutrition: _____	Urine: _____
Posture and Spine: _____	Blood Hemog. (desirable) _____	Allergy: Food: _____
Feet: _____	Nose: _____	Animals _____
Skin: _____	Throat: Tonsils: _____	Drugs: _____
Scabies: _____	Teeth: Position: _____	Other: _____

I believe this child is able to attend camp and participate in all camp activities with the following restrictions and recommendations:

To be completed by a Licensed Physician in order to attend Camp

INDIVIDUALIZED STANDING ORDERS FOR: Name _____ D.O.B. _____ Weight _____
Standard Over the Counter/PRN Medications (meds available in the Infirmary/First Aid Kit; to be administered at the discretion of a RN), if approval is indicated by the parent and camper's healthcare provider.

DRUG	ROUTE please circle preferred formulation (s)	DOSAGE	SCHEDULE	PROVIDER ORDER	COMMENTS
Tylenol	PO (chewable tabs, elixir, or tabs)	Per label Instructions by age/weight	Q 4 hr prn for pain or fever > _____	Yes / No	
Ibuprofen	PO (chewable tabs, suspension, or tabs)	Per label Instructions by age/weight	Q 6 hr prn for pain or fever > _____	Yes / No	
Robitussin	PO (syrup)	Per label Instructions by age/weight	Q 4 prn for cough	Yes / No	
Pepto-Bismol	PO (liquid, or chewable tabs)	Per label Instructions by age/weight	Q 30 min to 1 hour prn for diarrhea (no > 8 doses/24 hr)	Yes / No	
Children's Mylanta	PO (chewable tabs)	Per label Instructions by age/weight	BID-TID prn for stomach upset	Yes / No	
Dramamine	PO (chewable tabs 50 mg)	Per label Instructions by age/weight	Q 6-8 hrs prn for motion sickness	Yes / No	
Dimetapp	PO (elixir or tabs)	Per label Instructions by age/weight	Q 6-8 hr for nasal congestion/drainage	Yes / No	
Benadryl	PO (elixir, chewable tabs, or pills)	Per label Instructions by age/weight	Q 6 hr prn for allergic reaction (hives, insect bite)	Yes / No	
A&D Ointment	Apply to skin	Per label instructions by age/weight	Per label instructions by age/weight	Yes / No	
Calamine Lotion	Apply to skin	Per label instructions by age/weight	Per label instructions by age/weight	Yes / No	
Hydrogen Peroxide	Apply to skin	Per label instructions by age/weight	Per label instructions by age/weight	Yes / No	

PHYSICIAN'S SIGNATURE _____ **PRINT** _____

Provider Name: _____ Phone: _____

License # _____ Date: _____