

# Cloverbud Camp Registration and Health History Form

Office Use Only: Payment \_\_\_\_\_ Cabin: \_\_\_\_\_

This form must be completed for each participant by the parents/guardians of minors. This information will be kept confidential and used only for the welfare of the participant. Please print in ink or type.

### Identification:

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Which Camp Attending \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Age \_\_\_\_ Sex \_\_\_\_ School grade completed \_\_\_\_ School \_\_\_\_\_ Your 4-H County \_\_\_\_\_

Name of parent or guardian \_\_\_\_\_ Home Phone No. \_\_\_\_\_

Work Phone No. \_\_\_\_\_ Name of 1 possible cabin buddy \_\_\_\_\_

Is this person a 4-H member? Yes No (circle one)

### IN CASE OF EMERGENCY, CONTACT:

PARENT NAME \_\_\_\_\_ PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ PAGER \_\_\_\_\_

OTHER PERSON \_\_\_\_\_ Relationship \_\_\_\_\_ PHONE \_\_\_\_\_

OTHER PERSON \_\_\_\_\_ Relationship \_\_\_\_\_ PHONE \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

DENTIST'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

### Instructions for Medications

1. All prescription drugs MUST be carried in the container in which they were issued (with medical orders and physician's name intact), and given to the nurse/health director. Others will not be accepted. If your child is regularly taking medication, the attached medication release form must be completed including the doctor's signature.

No medication will be given without this completed form. The completed medication release form must accompany your child to camp.

List all medications your child needs to be given while at camp. Send ample supplies in original (child proof) containers with an affixed label including camper's name, name of medication, dosage, method and time of administration. Please list:

2. If you need over-the-counter medications not listed below, they must be in the original container and must be stored under lock and key by the nurse/health director or a responsible adult during the 4-H event. Please List:

**CHECK**

### MEDICATIONS BELOW, THAT PARTICIPANT MAY RECEIVE IF DEEMED NECESSARY:

\_\_\_\_nonaspirin pain medication/ \_\_\_\_Acetaminophen/tylenol/ \_\_\_\_laxatives/ \_\_\_\_ antacids \_\_\_\_ antiseptics/ \_\_\_\_diarrhea medication/ \_\_\_\_ Coriciden D/  
\_\_\_\_ Cough Syrup \_\_\_\_adrenalin / \_\_\_\_ others not listed, Please list:

3. Has your child had an illness or injury within the last 6 months that would limit activity for longer than one week? \_\_\_\_Yes \_\_\_\_No ( If you checked yes please explain.)

4. Has your child lost consciousness in the past 12 months during physical activity or had a concussion due to a head injury? \_\_\_\_Yes \_\_\_\_No ( If you answered yes please explain. Also please provide a statement from your physician).

5. Is your child currently being treated by a physician? \_\_\_\_Yes \_\_\_\_No ( If you checked "yes" please provide a statement from your physician indicating what current treatment is being given).

6. Is your child on a medically prescribed meal plan or do they require a special diet? \_\_\_\_Yes \_\_\_\_No ( If you checked "yes" please provide a copy of your child's diet to assist our cooks in preparing meals to meet his/her needs).

7. Is there any reason to restrict full activity, including swimming, long hikes, strenuous games? \_\_\_\_Yes \_\_\_\_No ( List any conditions limiting full participation, physical or emotional)

**Immunization Record:**

Please record the date (month & year) of basic immunizations and most recent booster doses

Vaccines	Month /Year of Basic Immunization	Year of Last Booster
Diphtheria	1	
Pertussis (whoopingcough)DPT*	2	1
Tetanus or	3	2
TetanusTD*		
Diphtheria or		
Tetanus		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given (most recent)		
Hemophilus influenza b (HIB)		

If your child has not had a tetanus shot within the last 7-10 years, please check with your physician so that your child can receive a tetanus inoculation (or booster) at least two weeks before they attend camp if needed.

**Check if Participant is Allergic to:**

- Foods (specify) :
- Medication: Prescription or non-prescription drugs (specify) :
- Serious Ivy, Oak, or Sumac Poisoning
- Bee or Insect Stings: Prescribed Treatment:

**LIST ALL PRESENT MEDICAL AND ALLERGIC CONDITIONS** (Contact Lenses, Braces, Diabetes, etc.) which require medication, treatment, or special restrictions or considerations in participation.:

Conditions:

Medications:

**Check below if participant is subject to:**

- headaches/  fainting/  heart trouble/  frequent colds/  constipation  convulsions /  frequent sore throats /  kidney trouble /
- athlete's foot /  sinusitis /  bed wetting /  sleep walking /  ear infection /  epileptic seizures /  home sickness /  bronchitis /
- cramps /  diarrhea /  asthma controlled (yes, no)  other please specify:

Explanations:

Does your child have any special equipment such as orthopedic or handicap devices, glasses, contacts, dentures, retainers?  Yes  No (If yes please list them)

**PARENT/GUARDIAN MEDICAL RELEASE**

\_\_\_\_\_ has my permission to participate in the Camp program and activities (with the exception of those restricted activities listed). I understand participants will be supervised. I understand the camp staff and volunteers, are not responsible in the event of accidental injury or illness, nor for the 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 transport the participant to an appropriate facility and I give the attending physician my permission 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 the treatment, referral, billing or insurance purposes.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**PHOTO RELEASE**

During 4-H Camp, we will be taking both digital and video pictures of camp activities. These pictures are a part of camp workshops and as records of camp activities. We hope to use some of the pictures to develop camp promotional piece(s). No names or other information will be used with the pictures. If you give permission for your child to be photographed participating in camp activities, please sign below:

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date