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Jamestown 4-H Educational Center

2019

Health History and Examination Form
Day Camp 2019

jamestown4hcenter.org

Name:_____ **Date of Birth** _____
Last First MI

Session:_____**Age:**_____ **Sex: M or F**

Contact Information

Parent or Guardian:_____ Relationship:_____

Home Address:_____
Street City State Zip

Home Phone ( ) _____ Business Phone ( )_____Cell ( )_____

Emergency Contact

Name:_____Relationship:_____

Home Address:_____
Street City State Zip

Home Phone ( ) _____ Business Phone ( )_____Cell ( )_____

Family Medical Information

Name of family physician:_____Phone ( )_____

Name of family dentist:_____ Phone ( )_____

Name of Insurer:_____Policy #_____

Carrier_____ Phone ( ) _____

Child Release Authorization– please list everyone authorized to pick child up (including parents)

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

Emergency Authorization

This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities except as noted. **Permission to Treat:** I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; 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 and 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.

Signature of Parent/Guardian:_____**Date:**_____

Photos may be used of my child for promotional purposes Yes ____ No ____

****This must be signed in order for your camper to attend camp****

Immunizations:

Are your child's immunizations up to date? Date of most recent tetanus shot? _____/_____
Yes _____ No ____ (month/year)

If your camper has not been fully immunized, please sign the following statement: I understand and accept the risks to my child from not being immunized. Signature _____ Date_____

Allergies: No known allergies. This camper is allergic to: Food Medicine
The environment (insect stings, hay fever, etc.) Other
(Please describe below what the camper is allergic to and the reaction seen.)

Diet, Nutrition: This camper eats a regular diet. This camper eats a regular vegetarian diet.
This camper has special food needs. (Please describe below.)

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

1. Ever been hospitalized? Yes No
2. Ever had surgery? Yes No
3. Have recurrent/chronic illness? Yes No
4. Had a recent infectious disease? Yes No
5. Had a recent injury? Yes No
6. Have diabetes? Yes No
7. Had seizures? Yes No
8. Had headaches? Yes No
9. Ever had back/joint problems? Yes No
11. Had fainting or dizziness? Yes No
12. Passed out/had chest pain during exercise? Yes No
13. Had "mono" during the past 12 months? Yes No
14. If female, have problems with menstruation? Yes No
15. Have problems sleepwalking? Yes No
16. Have a history of bedwetting? Yes No
17. Have any skin problems? Yes No
18. Wears glasses, contacts? Yes No
19. Had asthma/wheezing/shortness of breath? Yes No

Please explain "Yes" answers in the space below. (Please attach additional sheets with camper name/age if needed.)

Mental, Emotional and Social Health: Check "Yes" or "No" for each statement.
Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? Yes No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? Yes No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? Yes No
4. Had a significant life event that continues to affect the camper's life? Yes No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster)

Please explain "Yes" answers in the space below. The camp may contact you for additional information.

Restrictions:

☐ I have reviewed the program and activities of camp and feel the camper can participate without restrictions.
☐ I have reviewed the program and activities of camp and feel the camper can partcipate with the following restrictions or adaptations.

Medications: This camper will not take any daily medications while attending camp.
This camper will take the following daily medication(s) while at camp.

"Medication is any substance a person takes to maintain and/or improve their health." This includes vitamins and natural remedies. We require that all medications are in the original pharmacy container with the camper's name and physician's prescription. Please provide enough medication to last the entire time while at camp.

Medication	Route	Dosage	Schedule and Indications	Comments:

The following non-prescription medications are available in our Clinic. Our medical staff provide them for campers on an <u>as needed basis</u> to manage illness and injury. Please cross out those the camper should NOT be given.

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Robitussin
Pseudoephedrine decongestant (Sudafed)
Antihistamine/allergy medicine
Ivy Block/Tecnu
Calagel, Calamine, Hydrocortisone
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Sore Throat Spray
Bacitracin/First Aid Cream
Antacid (Mylanta, Tums, Pepto Bismol)
Aloe
Cough Drops