

COUNTY _____
LODGING _____
TRIBE/GROUP _____

HEALTH HISTORY

Must be completed for each participant and handed to the nurse upon arrival at camp. This form to be completed by parents/guardian of minors or by adult campers themselves. This information will be kept confidential and used only for the welfare of the participant.
PLEASE PRINT!

Camping Dates _____

Please Circle: Male Female Age _____ Date of Birth _____

Name _____ / _____ / _____
(Last) (First) (Middle)

Address _____ / _____ / _____ / _____
(P.O. Box or Street) (City) (State) (Zip)

Phone (home phone) _____ Parent/Guardian (work phone) _____

In Case of Emergency, contact:

Parent Name _____ Phone _____

Other Person _____ Phone _____

Physician's Name _____ Phone _____

INSTRUCTIONS FOR MEDICATION

1. All prescription drugs MUST be brought to camp in the container in which they were issued with medical orders and physician's name intact. Others will not be accepted.
2. Only exact amount of medication is to be brought to camp.
3. Pills must be counted upon arrival in camp and upon termination from camp by parent and nurse. No medications other than those prescribed by a physician should be brought to camp. Do not pack medication in suitcase. It must be given to the camp nurse at registration.

☐ Check medications below that participant may receive if deemed necessary, and administered by the camp nurse and/or attending physician:

___ Advil ___ Acetaminophen/Tylenol ___ Laxatives ___ Antacids ___ Adrenalin ___ Antiseptics
___ Decongestant ___ Cough suppressant ___ Diarrhea medication

PARENT/GUARDIAN OR ADULT CAMPER RELEASE

Are there any specific activities that this child cannot do at camp due to some health problem? Yes ___ No ___
If Yes, what are they? (For example: swimming, rappeling, canoeing, etc.) _____

Are there any specific activities at camp that should be especially encouraged with this child? Yes ___ No ___
If Yes, please explain _____

(Camper's Name) _____ has my permission to attend Canter's Cave 4-H Camp and to participate in rules and regulations of the camp or I, as parent/guardian, will assume responsibility of the child being sent home. I understand participants will be supervised. I understand that the staff and employees of Canter's Cave 4-H Camp, Ohio State University Extension and 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.

Parent/Guardian Signature _____ Date _____

HEALTH FORM

Name _____

Has this child been exposed to any contagious disease within 3 weeks before attending camp? Yes ___ No ___

If Yes, please explain: _____

Check below if participant is subject to:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fainting | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Frequent sore throat | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Athlete's foot | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Sleep walking |
| <input type="checkbox"/> Ear infection | <input type="checkbox"/> Epileptic seizures | <input type="checkbox"/> Home sickness | <input type="checkbox"/> Bed wetting/kidney trouble |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Pregnancy (last menstrual period _____) | |

Other (please specify) _____

Check if participant is allergic to:

Foods (specify) _____

Special Dietary Needs: _____

Medication: Prescription or non-prescription drugs (specify) _____

Bee/Insect Stings _____ Prescribed Treatment _____

Please check if you agree to have emergency aid administered on site _____

Other known allergies _____

List all present medical and allergic conditions and recommended restrictions _____

Conditions _____ Medications _____ Dosage _____

Specify any details of above or additional information _____

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

<u>VACCINES</u>	<u>DOSE 1</u>	<u>DOSE 2</u>	<u>DOSE 3</u>	<u>DOSE 4</u>	<u>DOSE 5</u>
Diphtheria, Tetanus, Pertussis - DTP					
Tetanus, Diphtheria - Td					
Tetanus					
Oral Polio (Sabin) - TOPV					
Injectable Polio (Salk)					
Measles, Mumps, Rubella - MMR					
Haemophilus Influenzae b - Hib					
Varicella - VZV (chicken pox)					
Hepatitis B					
Pneumococcal - PCV					
Tuberculin test given - TB					
Other					