

General Questions (Explain "yes" answers below.)



Disabilities accommodated with prior notification.

Has/does the participant:	Yes	No		Yes	No
1} Had any recent injury, illness or infectious disease?	[]	[]	16} Ever had back problems?	[]	[]
2} Have a chronic or recurring illness/condition?	[]	[]	17} Ever had problems with joints; e.g., knees, ankles?	[]	[]
3} Ever been hospitalized?	[]	[]	18} Have an orthodontic appliance being brought to camp?	[]	[]
4} Ever had surgery?	[]	[]			
5} Have frequent headaches?	[]	[]	19} Have any skin problems (e.g., itching, rash, acne)?	[]	[]
6} Ever had a head injury?	[]	[]	20} If female, have an abnormal menstrual history?	[]	[]
7} Ever been knocked unconscious?	[]	[]	21} Had problems with diarrhea/constipation?	[]	[]
8} Wear glasses, contacts or protective eye wear?	[]	[]	22} Had mononucleosis in the past 12 months?	[]	[]
9} Ever had frequent ear infections?	[]	[]	23} Have diabetes?	[]	[]
10} Ever passed out during or after exercise?	[]	[]	24} Had problems with sleepwalking?	[]	[]
11} Ever been dizzy during or after exercise?	[]	[]	25} Have asthma?	[]	[]
12} Ever had an eating disorder?	[]	[]	26} Have a history of bed-wetting?	[]	[]
13} Ever had chest pain during or after exercise?	[]	[]	27} Ever had seizures?	[]	[]
14} Ever had high blood pressure?	[]	[]	28} Ever had emotional difficulties for which professional help was sought?	[]	[]
15} Ever been diagnosed with a heart murmur?	[]	[]			

Please explain any 'yes' answers, noting the number of the questions. _____

Which of the following has the participant had?	Please give all dates of immunization for:						
	Vaccine: Dates: Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr						
[] Measles	DTP	_____	_____	_____	_____	_____	_____
[] Chicken Pox	TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
[] German measles	Tetanus	_____	_____	_____	_____	_____	_____
[] Mumps	Polio	_____	_____	_____	_____	_____	_____
[] Hepatitis A	MMR	_____	_____	_____	_____	_____	_____
[] Hepatitis B	or Measles	_____	_____	_____	_____	_____	_____
[] Hepatitis C	or Mumps	_____	_____	_____	_____	_____	_____
	or Rubella	_____	_____	_____	_____	_____	_____
TB Mantoux Test	Haemophilus influenza B	_____	_____	_____	_____	_____	_____
Date of last test	Hepatitis B	_____	_____	_____	_____	_____	_____
Result [] Positive [] Negative	Varicella (chicken pox)	_____	_____	_____	_____	_____	_____

Health History: The following information must be filled in by the parent -guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known Describe reaction and management of the reaction.

Medications allergies (list)

Food allergies (list)

Other allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.

Please list any **DIETARY RESTRICTIONS** that apply to this individual. _____

For Camp Use Only

Health History Reviewed by Camp Medical Personnel on: Date _____

Insurance Information

Is the participant covered by family medical/hospital insurance? [] Yes [] No
 If so, indicate carrier or plan name: _____ Group # _____
 Photocopy of front and back of health insurance card or current K-chip must be attached to this form.

Is there any additional information that camp staff should know to help your child be successful and have fun at camp? (behavioral, physical, emotional, special restrictions, etc.) If your child receives medication during the school year, we strongly urge you to keep your child on this medication during camp.

Name of family physician _____ Phone _____
 Address _____

Name of family dentist/orthodontist _____ Phone _____
 Address _____

**** Each 4-H camp participant is required to have a health exam within the past 24 months. The form below should be used.**

Health Exam for 4-H Camp Attendance
 To be completed by Licensed Medical Personnel
 A copy of a school or sports physical may be attached instead.

I have examined _____ (individual's name) on _____
 (the exam must be within the 24 months of camp attendance). BP _____ Weight _____ Height _____
 In my opinion the above applicant [] (is) [] (is not) able to participate in an active camp program.
 The applicant is under the care of a physician for the following conditions: _____

Any medical treatments to be continued at camp? _____
 Additional information for health care staff at camp _____

Signature of Licensed Medical Personnel _____
 LMP Name Printed _____ Title _____
 Address _____
 Phone _____ Date _____

****IMPORTANT- THIS BOX MUST BE COMPLETE FOR ATTENDANCE****

Parent/Guardian Authorizations: this health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer over the counter medication, assist in administering camper's prescription medications as needed, and seek emergency medical treatment including ordering x-rays and routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including trips out of camp.

Photo Use Permission: I grant the Kentucky 4-H Program and the University of KY, and persons acting through them, the right to use, reproduce, assign and/or distribute photographs, films, videotapes and sound recordings of myself or my minor child without compensation for use in promotion/advertising, educational publications, electronic publishing (websites) and personal memorabilia. Campers' names may be published.

***SIGNATURE APPLIES TO BOTH CONSENT TO TREAT AND PHOTO PERMISSION
 *CHECK "NO" BOX BELOW IF PHOTO PERMISSION IS DENIED**

Signature of parent/guardian (or adult volunteer/staff) _____

Printed Name _____ Date: _____

No To PHOTO PERMISSION