

# 4-H Camp Overlook Health Form

Due June 16, 2008

Week	CB	1	2	3	4	5	6	
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**Please allow your health care provider ample time to complete the physician section on the back of this form and return it to us.**

This form needs to be completed every year. Health Forms are not carried over from previous years. Campers cannot attend camp without this form. Health forms are due with your final payment on June 16<sup>th</sup>. Your health care provider can send the completed form to us at: 4-H Camp Overlook, 355 West Main Street, Suite 150, Malone, NY 12953 or by fax at 518-483-6214.

Please Print

Child's Name: \_\_\_\_\_ Parent / Guardian Name: \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Weight: \_\_\_\_\_ lbs.

Phone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

## If not available in an emergency, notify:

1. Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Please Print

Name of camper's physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Date of last physical examination: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Family Insurance Coverage

Name of Plan: \_\_\_\_\_ Health Insurance Company: \_\_\_\_\_

Name of Employer (if group): \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Policy Number: \_\_\_\_\_

## Health History (check if appropriate):

<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Heart Defect / Disease	<input type="checkbox"/>	Sinusitis
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Bleeding / Clotting	<input type="checkbox"/>	Frequent Earaches	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Sleepwalking
<input type="checkbox"/>	Athlete's Foot	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	Frequent Colds / Sore Throat	<input type="checkbox"/>	Menstrual Problems	<input type="checkbox"/>	

## Allergies

<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	Food: Please Specify	<input type="checkbox"/>	Environmental: Please Specify	<input type="checkbox"/>	Other Drug Allergies:	<input type="checkbox"/>	Other Allergies:
<input type="checkbox"/>	Hay Fever		_____		_____		_____		_____
<input type="checkbox"/>	Insect Stings		_____		_____		_____		_____
<input type="checkbox"/>	Poison Ivy		_____		_____		_____		_____

**Additional Information:** To ensure a successful summer for your child and other campers, please provide any information about the participant's behavior and physical, emotional, or mental health which the camp should be aware:

\_\_\_\_\_

## Current Condition or Special Needs:

Please describe any recent illness, injury, existing medical condition, restriction or special need that your child has.

\_\_\_\_\_

Special Dietary Needs: \_\_\_\_\_

## Emergency Authorization

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the adult leader in charge to hospitalize, secure proper anesthesia, or to order injection or surgery for my son or daughter.

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Form 2

**Camper's**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Weight \_\_\_\_ lbs.

**Immunization Record**

Please fill in the following immunization chart or attach a copy of the campers immunization record.

Vaccine	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr
Diphtheria, Pertussis (Whooping Cough), Tetanus (DPT)				
Tetanus, Diphtheria (TD)				
Diphtheria				
Tetanus				
Oral Polio (Sabin) TOPV				
MMR				
Measles (Hard Measles, Red Measles, Rubella)				
Mumps				
Rubella (German Measles, 3 day measles)				
Haemophilus Influenza B (HIB)				
Varicella (Chicken Pox)				
Hepatitis B				
Other				
TB Mantoux Test: Date of last test _____ Result (positive or negative)				

**Physician's Section**

**NOTE: If a licensed health care provider does not sign this form, the camper will not be given any prescription or over the counter medication.** Please allow your health care provider ample time to complete this form and return it to us.

**Health Care Recommendations:** Please complete with patient's current regimen for both scheduled and prn medications – use 2<sup>nd</sup> page if needed. Please bring all regularly taken medications (prescription and over the counter) to the camp nurse when registering.

Drug Name	Route <small>Please circle preferred formulation</small>	Dosage	Schedule and Indications	Health Care Provider Order	Comments
<b>Prescription Medications</b>					
<b>Over The Counter</b>					
<b>Tylenol</b>	PO - Chewable tabs, elixir or tabs	Per label instructions by age/weight	Q 4 hr prn for pain or fever > ____ °F	Yes No	
<b>Ibuprofen</b>	PO - Chewable tabs, suspension, or tabs	Per label instructions by age/weight	Q 6 hr prn for pain or fever > ____ °F	Yes No	
<b>Robitussin</b>	PO - Syrup	Per label instructions by age/weight	Q 4 hr prn for cough	Yes No	
<b>Pepto-Bismol</b>	PO - Chewable tabs, or liquid	Per label instructions by age/weight	Q 30 min to 1 hr prn for diarrhea (no > 8doses/24hr)	Yes No	
<b>Children's Mylanta</b>	PO - Chewable tabs	Per label instructions by age/weight	TID-QID prn for stomach upset	Yes No	
<b>Tums</b>	PO - Chewable tabs	Per label instructions by age/weight	BID-TID prn for stomach upset	Yes No	
<b>Dimetapp</b>	PO - Chewable tabs - 50 mg	Per label instructions by age/weight	Q 6-8 hr prn for nasal congestion/drainage	Yes No	
<b>Benadryl</b>	PO - Elixir, chewable tabs, or pills	Per label instructions by age/weight	Q 6 hr prn for allergic reaction (hives, insect bite)	Yes No	
<b>Midol</b>	PO - Chewable tabs, or liquid	Per label instructions by age/weight	Q 4-6 hr prn for menstrual symptoms	Yes No	
<b>Imodium AD</b>	PO - Tabs	Per label instructions by age/weight	1 caplet after 1 <sup>st</sup> BM, and ½ caplet after each subsequent loose BM	Yes No	

Health Care Provider Name: \_\_\_\_\_

Phone: \_(\_\_\_\_)\_\_\_\_\_

Address: \_\_\_\_\_

License # \_\_\_\_\_

Health Care Provider Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_