

HEALTH FORM

Attach current photo here. Photo will not be returned.

4-H Camp

County _____

Dorm and/or Room Number _____

Name _____

Birthdate _____

Street Address _____

City _____

State _____

ZIP code _____

(_____) _____
Day Phone Number

Evening Phone Number _____

Youth Cell (If applicable) _____

List any activities the participant should avoid (i.e., swimming): _____

Physical Record of Participant

Yes

No

Heart Condition _____

Diabetes _____

Ear Infections _____

Bedwetting _____

Allergy to any medication _____

List medicines allergic to: _____

Food allergies or dietary restrictions _____

List allergies/restrictions: _____

Other allergies (i.e., dust, pollen, animals) _____

List other allergies _____

All immunizations required for school are current _____

Date of last tetanus shot: _____

Please list any current medication being taken on reverse side of this form.

Please describe any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while at camp: _____

PARENTAL AUTHORIZATION

Pursuant to Indiana Code Paragraph 16-36-1-6 and subject to any limitations listed below, I request and authorize Purdue University Cooperative Extension Service employees and their authorized agents to arrange for all reasonably necessary medical care, including transportation and hospitalization, for my child while in attendance at and participating in 4-H Youth Development events and activities.

I also understand that, as a result of my child's participation in this program, it will be necessary for Purdue CES employees and other authorized personnel with the program to have access to relevant medical information pertaining to my child, and I authorize the use and disclosure of my child's medical information to promote a safe and healthy experience for my child.

Parent/Legal Guardian Signature _____

Date _____

Witness to Parent/Legal Guardian _____

Date _____

Parent/Guardian Telephone: (_____) _____
Home

(_____) _____
Work

Both above signatures required for acceptance to participate

In case we cannot reach you, please list the name and phone number of a second party to contact:

Name _____

Address _____

Telephone: (_____) _____
Home

(_____) _____
Work

Please complete the addendum on reverse side

ADDENDUM TO THE 4-H CAMP YOUTH HEALTH FORM

Complete this form for **prescription medications and over-the-counter medications** that are being taken by the student at the time of the event. These medications will be administered by an Extension staff member or other authorized personnel.

Medications must be carried in their original containers.

County: _____

4-H member's Name: _____

Name of Medication: _____

What Illness/Condition is this medication intended for: _____

Check any of the following that apply:

_____ Tylenol/Ibuprofen may be administered by 4-H Youth Development event personnel

_____ Benadryl may be administered by 4-H Youth Development event personnel

Youth's weight: _____ lbs.

Dosage: _____ Refrigeration? Yes _____ No _____

Special Instructions: _____

Other information (if applicable): _____

Date(s) to Administer: From _____ To _____

Prescribing Doctor's Name: _____ Phone: () _____

Event: _____ Date (s): _____

Signature of Parent/Legal Guardian Date

Signature of Parent/Legal Guardian Date