## **HEALTH FORM**

Attach current photo here. Photo will not be returned.

## 4-H Camp

County		Dorm ar	nd/or Room	Number	
Name			Birthdate		
Street Address	City	State	ZI	P code	
() Day Phone Number	Evening Phone Number		Youth Cell (If applicable)		
List any activities the participant shou	uld avoid (i.e., swimming):				-
Physical Record of Participant Heart Condition Diabetes			<u>Yes</u>	<u>No</u>	-
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, anir	mala)				
Conter allergies (i.e., dust, pollen, animals)  List other allergies  All immunizations required for school are current				<del></del>	
Date of last tetanus shot: Please list any current medication					
Please describe any current physical restrictions or considerations while at					oecia
	PARENTAL AUTHOR	RIZATION			
Pursuant to Indiana Code Paragraph Purdue University Cooperative Exter reasonably necessary medical care, at and participating in 4-H Youth Dev	sion Service employees a including transportation ar	nd their authorize nd hospitalization,	d agents to	arrange for all	
I also understand that, as a result of employees and other authorized pers pertaining to my child, and I authorize and healthy experience for my child.	sonnel with the program to	have access to re	elevant me	dical information	
Parent/Legal Guardian Signature	Date Witness to Pare	ent/Legal Guardian		Date	
Parent/Guardian Telephone:()_ Home		() Work			
Both about In case we cannot reach you, please	ve signatures required for a list the name and phone r			contact:	
Name			. ,		
Address					
Telephone: ()	(	)			
Home Please complete the addendum on rev	verse side	Work			

## ADDENDUM TO THE 4-H CAMP YOUTH HEALTH FORM

Complete this form for <u>prescription medications</u> and <u>over-the-county medications</u> 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 <u>must</u> be carried in their original containers.

County:	
4-H member's Name:	
Name of Medication:	
What Illness/Condition is this medication intend	led for:
Check any of the following that apply: Tylenol/lbuprofen may be administered Benadryl may be administered by 4-H Y	
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