

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: \_\_\_\_\_

Dietary restrictions \_\_\_\_\_

List dietary 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

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