

4-H Camp Ohio

This form must be completed for each participant. Minors must have the form completed and signed by parents/guardians. This information will be kept confidential and used only for the welfare of the participant.

**Please
Attach
Picture**

Participant/Member Information:

Name: _____			
(Last)	(First)	(Middle)	
Address: _____			
(Street)	(City)	(State)	(Zip)
Home Phone: ()		County:	
Date of Birth:		Male/Female	Age:

Emergency Contact Information:

Parent Name:	Parent Cell Phone: ()
Other Contact:	Other Cell Phone: ()
Physician:	Physician Phone: ()
Dentist:	Dentist Phone: ()

Health History:

Communicable Diseases:

Provide an approximate date at which participant has had or been exposed to any of the following:

Chicken Pox: _____ Measles: _____ Whooping Cough: _____
 Tuberculosis: _____ Mumps: _____
 Other communicable diseases: _____ Date of Last Menstrual Period: _____

Immunization/Vaccine Record:

- | | | | |
|--|---|---|------------------------------------|
| <input type="checkbox"/> Hepatitis B (HepB) | <input type="checkbox"/> Inactive Poliovirus (IPV) | <input type="checkbox"/> Pneumococcal (PCV) | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Diphtheria, Tetanus, Pertussis (DTap) | <input type="checkbox"/> Measles, Mumps, Rubella(MMR) | <input type="checkbox"/> Hepatitis A (HepA) | |
| <input type="checkbox"/> Haemophilus influenza type b (HIB) | <input type="checkbox"/> Meningococcal (MCV4) | <input type="checkbox"/> Varicella | |

The participant is current or up-to-date on the above vaccines and immunizations: _____ (Initial Here)

If the participant is **not** current or up-to date on the above vaccines and immunizations, please explain:

Provide the date of the participants last Tetanus shot: _____

List any past medical treatment, if any (physical, mental or psychological): _____

Medical Instructions: Medications, Allergies, Current Medical Conditions:

Current Medications and Conditions: (please list additional medications or needs on a separate sheet)

Name of Medication:	Dosage:	Frequency/Instructions:

Check below if the participant is subject to any of the following conditions:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Cramps
<input type="checkbox"/> Fainting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Sleep Walking	<input type="checkbox"/> Home Sickness	<input type="checkbox"/> Asthma Controlled? yes / no
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Athlete's Foot	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Other? _____

Allergies:

Food allergies: _____

Medication allergies: _____

Serious Ivy, Oak or Sumac Poisoning: What is the prescribed treatment? _____

Serious bee or insect sting Reactions: What is the prescribed treatment? _____

Instructions for Medications:

- All prescription drugs must be carried in the container in which they were issued (with medical orders and physician’s name intact) and given to the nurse/health director. Others will not be accepted. Only bring the amount needed for your stay at camp.
- If you need over-the-counter medications not listed below, they must be in the original container and must be stored under lock and key by the nurse/health director.
- The nurse/health director may administer any of the following medications (please check all that apply):

- | | | | | |
|---|---|--|---|---------------------------------------|
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Benadryl | <input type="checkbox"/> Caladryl | <input type="checkbox"/> Calamine | <input type="checkbox"/> Cholraseptic |
| <input type="checkbox"/> Claritin | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Immodium | <input type="checkbox"/> Insect Repellent | <input type="checkbox"/> Maalox |
| <input type="checkbox"/> Milk of Magnesia | <input type="checkbox"/> Neosporin Ointment | <input type="checkbox"/> Robitussin DM | <input type="checkbox"/> Silvadene Cream | <input type="checkbox"/> Sudafed |
| <input type="checkbox"/> Suscreen | | | | |

Emergency Medical Release:

Please check one of the following options and sign below.

_____ **To Grant Consent:** We will notify you if our health care provider thinks your child should go to the doctor or emergency room. In the event reasonable attempts to contact you and the additional emergency contact have been unsuccessful, **I hereby give my consent for:** (1) the administration of any treatment deemed necessary by the preferred physician and preferred dentist listed on the front of this form, or in the event the designated practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to appropriate hospital or urgent care center reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

_____ **To Deny Consent: I do not give consent** for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish 4-H Camp Ohio and the sponsoring agency authorities to take no action or to

Signature

Date

Photo/Video Release:

I give permission to The Ohio State University, OSU Extension, the Ohio 4-H program and 4-H Camp Ohio to use photographs, voice and video images of the participant named above and photographs, voice and video images of any activities in which the participant is involved in any and all public awareness programs of The Ohio State University, OSU Extension, the Ohio 4-H program and 4-H Camp Ohio.

Signature: _____

Date: _____

Camp Program Release:

_____ has my permission to participate in the Ohio 4-H program and activities as listed on the 4-H Camp Ohio website (with the exception of those restricted activities listed). I understand participants will be supervised. I understand the 4-H staff and volunteers; The Ohio State University Extension and The Ohio State University are not responsible in the event of accidental injury or illness, nor for the compounded injury of illness to the participant’s present medical conditions listed. I further understand in case of serious injury or illness I will be notified. I am aware in signing this statement for participation in programs of 4-H Camp Ohio that certain activities are physically demanding. Therefore, physical fitness will increase the enjoyment and ability to participate in the activity. If, for any reason, I question the ability of the participant to participate in the activity, I will consult with the instructors prior to participation. While it is impossible to foresee all possible dangers, some of the specific hazards which might be encountered while participating in camp programs include: slipping or falling on the trail, bumps, bruises, cuts, insect bites, poison ivy, sprains, fractures or other injuries. I understand that most activities are conducted in the out-of-doors in all kinds of weather, so proper dress (rain gear, warm clothing) are essential to avoid undue exposure to known risks; however, as a participant, I acknowledge the nature of the activity and the fact that not all of the stresses and hazards connected with the activity can be foreseen. I have the personal responsibility to follow the established safety rules and procedures to the extent that I participate in such activities. If at any time I have questions about the activity, I have the responsibility to consult with my instructor. Sponsoring agencies have the responsibility of providing a progression of appropriate activities which lead to the experiences at 4-H Camp Ohio.

Signature: _____

Date: _____