

UK COOPERATIVE EXTENSION SERVICE

UNIVERSITY OF KENTUCKY — COLLEGE OF AGRICULTURE



Registration/Health Form

Kentucky 4-H Camp

for ALL CAMPERS, VOLUNTEERS and Camp Staff

(Campers on white, Adults on light green, Teens on light blue)

For Office use Only:	Mail this form to the address below by _____ (date)	Dates of Camp Attendance
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This information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history must be filled out by parents/guardians of minors or by adults themselves. Update required annually.

It is recommended that the Health Exam be completed by approved licensed medical personnel at least every two years. The Camper Medication Form (separate page) must be completed just prior to attending camp.

Name _____ Birth Date _____ Age at camp _____
LAST FIRST MIDDLE

Home address _____
STREET ADDRESS CITY STATE ZIP

Social security number of participant: _____ - _____ - _____ Phone _____ Race* _____ [] Male [] Female
*Necessary to comply with affirmative action-Civil Rights Standard

Have you ever attended 4-H week-long camp before? Yes _____ No _____ For how many years? _____

School Grade (entering) _____ Were you eligible for Free/Reduced meals at your school this past year? _____

Custodial parent/guardian _____ Phone: _____ Cell: _____

Home address _____
STREET ADDRESS CITY STATE ZIP

Business address _____ Phone: _____
STREET ADDRESS CITY STATE ZIP

Second parent or guardian or emergency contact _____ Cell: _____

Address _____ Phone: _____
STREET ADDRESS CITY STATE ZIP

Business address _____ Phone: _____
STREET ADDRESS CITY STATE ZIP

If not available in an emergency, notify:
 Name _____
 Relationship _____ Phone: _____
 Address _____ Cell: _____
STREET ADDRESS CITY STATE ZIP

Year _____
County _____

Important – This box must be complete for attendance*

Parent/Guardian Authorizations: this health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer over the counter medications, assist in administering camper's prescription medications as needed, and seek emergency medical treatment including ordering x-rays and routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian (or adult volunteer/staff) _____ Date: _____
 Printed Name _____

Photo Use Permission I grant the Kentucky 4-H Program and the University of Kentucky, and persons acting through them, the right to use, reproduce, assign and/or distribute photographs, films, videotapes and sound recordings of myself or my minor child without compensation for use in promotion/advertising, educational publications or electronic publishing (web sites) which they may create. Children's names will not be published.

Signature of parent/guardian (or adult volunteer/staff) _____ Date: _____
Educational programs of the Kentucky Cooperative Extension Service serve all people regardless of race, color, age, sex, religion, disability, or national origin.

Participant Name _____
Original of the Registration/Health form must be kept on file at camp.

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No
 If so, indicate carrier or plan name: _____ Group # _____

Photocopy of front and back of health insurance card or current K-chip must be attached to this form.

General Questions (Explain "yes" answers below.)



Disabilities accommodated with prior notification.

Has/does the participant:

	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints; e.g., knees, ankles?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Had problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any 'yes' answers, noting the number of the questions. _____

Which of the following has the participant had?

- Measles
- Chicken Pox
- German measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

TB Mantoux Test

Date of last test _____

Result Positive Negative

Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
	or Measles	_____	_____	_____	_____	_____	_____
	or Mumps	_____	_____	_____	_____	_____	_____
	or Rubella	_____	_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____	_____	_____

Health History: The following information must be filled in by the parent -guardian, or adult camper or staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care.

Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known Describe reaction and management of the reaction.

Medications allergies (list)

Food allergies (list)

Other allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.

Please list any **DIETARY RESTRICTIONS** that apply to this individual. _____

For Camp Use Only

Health History Reviewed by Camp Medical Personnel on: Date _____

Is there any additional information that camp staff should know to help you child be successful and have fun at camp? (behavioral, physical, emotional, special restrictions, etc.) If your child receives medication during the school year, we strongly urge your to keep you child on this medication during camp. _____

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

It is recommended that each 4-H camp participant has a health exam within the past 24 months. The form below should be used.

Health Exam for 4-H Camp Attendance
To be completed by Licensed Medical Personnel
A copy of a school or sports physical may be attached instead

I have examined _____ (individual's name) on _____ (the exam must be within the 24 months of camp attendance). BP _____ Weight _____ Height _____

In my opinion, the above applicant [] is [] is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions: _____

Recommendations and Restrictions at Camp

Treatment to be continued at camp: _____

Medications to be administered at camp (name, dosage, frequency): _____

Any medically-prescribed meal plan or dietary restrictions: _____

Known allergies: _____

Description of any health limitation or restriction on camp activities: _____

Additional information for health care staff at camp: _____

Signature of Licensed Medical Personnel _____

LMP Name Printed _____ Title _____

Address _____

Phone _____ Date _____

FOR ADULT VOLUNTEERS ONLY

I, _____, an Adult Volunteer, grant permission for the use of my personal vehicle, if needed, for transportation (e.g. visits to the doctor or hospital in emergencies and to and from camp). In doing so I state that I have an adequately maintained vehicle. _____

SIGNATURE

DATE



PICK-UP/RELEASE FORM



This section must be completed or your child will not be permitted to attend 4-H Camp.

I, the parent/guardian/foster parent of _____ have read the following statement and I agree to comply.

My child will return from 4-H camp on _____ at _____ (a.m. or p.m.)

The bus will unload at _____.

It is the parents/guardians' responsibility to arrange to pick-up their child/children upon their return from camp at the above time.

There will be no exception to this policy regardless of relationship to the child. Please inform everyone approved by you on this release, that they must have on their person a current driver license or photo ID before the child will be released into their custody. IF A CAMPERS PARENTS ARE SEPARATED OR DIVORCED, UNLESS THE CAMP IS PROVIDED WITH A COPY OF A KENTUCKY COURT ORDER TO THE CONTRARY, BOTH BIOLOGICAL OR ADOPTIVE PARENTS HAVE ACCESS TO THE CAMPER.

CAMPERS NAME: _____ COUNTY: _____

FATHERS NAME: _____ CELL PHONE: () _____

HOME PHONE: () _____ WORK PHONE: () _____

MOTHERS NAME: _____ CELL PHONE : () _____

HOME PHONE: () _____ WORK PHONE: () _____

If divorced, which parent is assigned custody: _____

The camper named above has my permission to be picked up by person(s) listed below. I understand my child cannot be picked up from the campgrounds by anyone except his/her guardians unless they are on this list.

NAME: _____ RELATIONSHIP _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

My child has permission to walk home from the Camp bus drop-off site. I understand that this permission may be rescinded due to conditions (bus arrives after dark, bad weather, etc.) and that I will be contacted if this occurs.

Signature: _____ Date: _____

BY SIGNING THIS, I ACKNOWLEDGE THAT I HAVE READ ALL THE ABOVE INFORMATION RELATED TO PICKING UP MY CHILD WHEN HE/SHE RETURNS FROM 4-H CAMP, AND I HAVE INSTRUCTED MY CHILD THAT THEY ARE TO LEAVE WITH NO ONE UNLESS LISTED ABOVE. HE/SHE ALSO HAS BEEN TOLD TO REPORT IMMEDIATELY TO THE AGENT IF THE DESIGNATED PERSON(S) IS/ARE NOT PRESENT AT THE TIME THE BUS ARRIVES.

SIGNATURE _____ DATE _____

RELATIONSHIP TO THE CHILD: _____