

# 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) \_\_\_\_\_  
 Printed Name \_\_\_\_\_ Date: \_\_\_\_\_

**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. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Had problems with diarrhea/constipation?	<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. Have diabetes?	<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. Have asthma?	<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 an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had seizures?	<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 your 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 you to keep your child on this medication during camp. \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**\*\* Each 4-H camp participant is required to have a health exam within the past 24 months. The form below should be used. For exemptions, see your County 4-H Agent.**

**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