

RETURN TO:

PURDUE UNIVERSITY CES
 GIBSON COUNTY EXTENSION
 800 S. PRINCE ST. RM. 35
 PRINCETON, IN 47670

COMPLETE BOTH SIDES OF APPLICATION!

**REGISTRATION and HEALTH FORM
 FOR KENTUCKY 4-H CAMP
 CAMP DATES: JUNE 5-7, 2009**

COST: \$75

Grades 3-7 Only

DUE 5-11-2009

Make checks to:

GIBSON COUNTY 4-H, INC.

County _____

Camper's Name _____ Date of Birth _____

Address _____
 Route or street City State Zip code

Age _____ Gender: Circle M or F RACE* _____ *Necessary to comply with affirmative action -- Civil Rights Standard

Have you attended 4-H Camp before? Yes _____ No _____ For how many years? _____

School attended _____ Grade in School as of May 1 of Current Year _____

Custodial parent/guardian _____ Phone: _____ Cell: _____

Home address _____
 Route or street City State Zip code

Business address _____
 Route or street City State Zip code

Second parent/guardian/emergency contact _____ Cell: _____

Address _____ Phone: _____
 Route or street City State Zip code

If not available in an emergency, notify:

Name _____
 Relationship _____ Phone: _____
 Address _____ Cell: _____
 Route or street City State Zip code

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 prescribed and over the counter medications, 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 _____

Printed Name

Date

Photo Use Permission

I grant the Kentucky 4-H Program, the University of Kentucky, Purdue Extension, 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 _____ Date _____

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier or plan name: _____ Group # _____

PHOTOCOPY (FRONT & BACK) OF HEALTH INSURANCE CARD 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?

Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Measles	DTP	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Chicken Pox	TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> German measles	Tetanus	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	Polio	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	MMR	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	or Measles	_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Mumps	_____	_____	_____	_____	_____	_____
	or Rubella	_____	_____	_____	_____	_____	_____
TB Mantoux Test	Haemophilus influenza B	_____	_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B	_____	_____	_____	_____	_____	_____
Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Varicella (chicken pox)	_____	_____	_____	_____	_____	_____

Use this space to provide additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware.

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

HEALTH HISTORY

The following information must be filled in by the parent/guardian. 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

Medications allergies (list) Describe reaction and management of the reaction.

Food allergies (list) Describe reaction and management of the reaction.

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc. Describe reaction and management of the reaction.

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

