UNIVERSITY OF MARYLAND EXTENSION

MARYLAND 4-H CAMP HEALTH FORM

Current Photo Of Camper

Camper's Name: _____
Last *First* *MI* *Nickname*

Sex:
☐ Male
☐ Female

Gender Identity:
☐ Male ☐ Nonbinary
☐ Female ☐ Other
☐ Prefer not to State

Camp Dates:
_____ to _____
MM/DD/YYYY *MM/DD/YYYY*

Age at Camp Arrival: _____
Birthdate: _____
MM/DD/YYYY

Home Address: _____
Street Address
_____
City *State* *ZIP* *County*

School Attended: _____
County: _____ ☐ Private ☐ Public ☐ Other _____

School Address: _____
Street Address *City* *State* *ZIP*

PARENT/GUARDIAN or Other Person be Notified in case of Injury or Illness:

Name: _____ Relationship: _____ Preferred #1 _____
Phones: #2 _____
Indicate mobile (M), home (H), work (W)
E-mail: _____

Home Address: _____
if different from camper *Street Address* *City* *State* *ZIP*

SECOND PARENT/GUARDIAN or Other Emergency Contact:

Name: _____ Relationship: _____ Preferred #1 _____
Phones: #2 _____
Indicate mobile (M), home (H), work (W)
E-mail: _____

ADDITIONAL CONTACT in event parent/guardian or others cannot be reached:

Name: _____ Relationship: _____ Preferred #1 _____
Phones: #2 _____
Indicate mobile (M), home (H), work (W)
E-mail: _____

HEALTH CARE PROVIDER CONTACTS

	Name:	Phone:
Primary Care Physician:		
Dentist:		
Other (Specify): _____		

HEALTH INSURANCE:

Is camper covered by health/medical insurance? ☐ Yes ☐ No

Insurance Company: _____ Phone Number: _____

Policyholder's Name: _____ Policy Number: _____

Attach photocopy of insurance card; be sure to copy both sides of card so information is readable

CAMPER HEALTH SUMMARY

(***Camp Use*** - *See additional pages for detailed health history)*

☐ Camper has mild/moderate allergies
☐ Camper has **severe** allergies that require immediate medical attention: _____
☐ Camper carries an Epi-pen, inhaler, or other emergency device: _____

☐ Camper takes daily medication
☐ Camper has dietary needs or restrictions
☐ Camper has physical limitations or disability
☐ Camper has personal issues/needs: _____

UNIVERSITY OF MARYLAND EXTENSION

CAMPER HEALTH HISTORY Page 2

Camper's Name: _____
Age: _____ Birthdate: _____

IMMUNIZATION CERTIFICATION

State in which camper attends school: _____

Date of last Tetanus immunization: _____

Is camper exempt from any immunizations? ☐ Yes ☐ No
List: _____

CERTIFICATION: I certify my child has received and is up-to-date on all immunizations required for school attendance in the state where they attend. If my child has not received required immunizations, I certify the appropriate exemptions or exceptions have been recorded with my child's school. I understand and accept the risks of my child not being fully immunized per state requirements.

Signature of Parent/Guardian: _____ **Date:** _____ **Relationship to Camper:** _____

GENERAL HEALTH HISTORY

Check "Yes" or "No" for each statement. Explain "yes" answers in space below.

Has/does the Camper:

1. Ever been hospitalized?	☐ Yes	☐ No	12. Had fainting or dizziness	☐ Yes	☐ No
2. Ever had surgery?	☐ Yes	☐ No	13. Passed out/had chest pain during exercise?	☐ Yes	☐ No
3. Have a recurrent/chronic illness?	☐ Yes	☐ No	14. Had mononucleosis (mono) in the last month?	☐ Yes	☐ No
4. Had a recent infectious disease?	☐ Yes	☐ No	15. If female, had problems with period/menstruation?	☐ Yes	☐ No
5. Had a recent injury?	☐ Yes	☐ No	16. Have problems with falling asleep or sleepwalking?	☐ Yes	☐ No
6. Had a recent head injury or concussion?	☐ Yes	☐ No	17. Ever had back/joint problems?	☐ Yes	☐ No
7. Had asthma/wheezing/shortness of breath?	☐ Yes	☐ No	18. Have a history of bedwetting?	☐ Yes	☐ No
8. Have diabetes?	☐ Yes	☐ No	19. Have problems with diarrhea or constipation?	☐ Yes	☐ No
9. Had seizures?	☐ Yes	☐ No	20. Have any skin problems?	☐ Yes	☐ No
10. Had headaches?	☐ Yes	☐ No	21. Traveled outside the country in the past 9 months?	☐ Yes	☐ No
11. Wear contact lenses, glasses, or protective eyewear?	☐ Yes	☐ No	22. Have any other condition or issue not listed?	☐ Yes	☐ No

Explain "yes" answers in the space below, noting the question number. For travel outside the country, list countries visited and dates of travel.

ALLERGIES

☐ No known allergies ☐ Allergic to: Foods Medicines Environment Other *(Circle all that apply & describe below)*

What is camper allergic to? (Specific) | What is the typical reaction seen? | What is treatment is needed?

Attach additional pages if needed

DIET/NUTRITION

☐ Eats regular diet
☐ Eats regular vegetarian diet
☐ Lactose intolerant
☐ Glucose intolerant
☐ Other (*Please explain below)*

***Notes about camper's diet/nutrition**:*

MENTAL, EMOTIONAL, AND SOCIAL HEALTH

Check "yes" or "no" for each statement.

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)?	☐ YES	☐ NO
2. Ever been treated for emotional or behavioral difficulties or an eating disorder?	☐ YES	☐ NO
3. In the past 12 months, seen a professional to address mental/emotional health concerns?	☐ YES	☐ NO
4. Had a significant life event that continues to affect the camper's life? *(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc)*	☐ YES	☐ NO
5. Is this the camper's first time away from home/family for an overnight event?	☐ YES	☐ NO

Please explain "yes" answers in the space below, noting the number of the question. Attach additional pages if needed. The camp may contact you for additional information.

CAMPER HEALTH HISTORY Page 3

Camper's Name: _____
Age: _____ Birthdate: _____

ADDITIONAL INFORMATION:	Please provide any additional information about the camper's health or well-being you think may be important for staff to know or that may affect the camper's ability to fully participate in the camp program. Attach additional pages if needed.
RESTRICTIONS:	☐ I have reviewed the program and activities of the camp and feel the Camper can participate without restrictions. ☐ I have reviewed the program and activities of the camp and feel the Camper can participate with the following restrictions or adaptations (please describe):

AUTHORIZATION FOR PARTICIPATION, TREATMENT, AND RELEASE OF LIABILITY

I certify that this health history is correct and accurately reflects the health status of the camper to whom it pertains. I hereby give permission for medical personnel selected by University of Maryland Extension (UME) to provide routine health care; to order x-rays, and routine tests; to administer medications, injections, anesthesia, surgery, and other treatment; to release records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission for medical personnel selected by UME to secure and administer treatment including hospitalization for the participant named above. I further understand that I will be responsible for medical/hospital bills. By signing this form, I give permission for the participant named above to participate in all program activities except as specified herein. This completed form may be copied for trips out of camp and/or away from the program site. By signing this form, I release and forever discharge, agree not to sue, and to indemnify and hold harmless the State of Maryland, University of Maryland, and University of Maryland Extension and/or their officers, agents, employees, faculty, staff, and volunteers from and against any and all liabilities, costs, expenses, causes of action, claims, and/or demands in any way relating to the foregoing program activities and/or the health, illness, injury, and/or treatment of the participant named above.

Signature of Parent/Guardian: _____ **Date:** _____ **Relationship to Camper:** _____

Signature of Adult Camp Participant: _____ **Date:** _____

Camper's Name: _____
Age: _____ Birthdate: _____

MEDICATIONS

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. Campers who will take daily medications, vitamins, supplements, etc. while attending this 4-H Camping Program must complete the **Medication Administration Authorization Form,** which must be signed by **BOTH** the Camper's Parent/Guardian and the prescribing Physician. Campers who will take daily medications must bring their own supply of prescription or non-prescription medications, and the supply must be provided by an adult to the Camp Staff upon arrival. See pages 5-6 for the Medication Administration Authorization form and further instructions.

Check the applicable statement below:

☐ Camper **WILL NOT** bring/take daily medication(s), vitamins, or supplements while attending camp.

☐ Camper **WILL** bring/take daily medication(s), vitamins, or supplements while attending camp.*
Medication Administration Authorization Form is required

CAMP HEALTH CENTER MEDICATIONS & REMEDIES

The Camp will stock certain non-prescription medications and remedies in the Camp Health Center that may be used on **a <u>one-time</u> or <u>limited as-needed</u> basis** to manage minor illness and injury. Dosages of these medications and remedies will be administered according to directions on the label unless the Camper's Parent/Guardian provides written direction provided for alternate dosage or use. Check the boxes below to select which medications/remedies from the Camp Health Center you authorize the Camp Staff to administer to your Camper, according to general labeling instructions. Note any alternate use/dosage directions in the comments below, specifying **EXACTLY** <u>which</u> medication/remedy may be used other than as directed, and <u>how</u> it may be used for your Camper.

☐ Acetaminophen (i.e. Tylenol)	☐ Antihistamine/allergy medicine	☐ Aspirin
☐ Ibuprofin (i.e. Motrin, Advil)	☐ Pseudoephedrine decongestant (i.e. Sudafed)	☐ Cough drops
☐ Naproxen/NSAID (i.e. Aleve)	☐ Guaifenesin cough syrup (i.e. Robitussin)	☐ Antibiotic cream
☐ Pepto-Bismol (for upset stomach/diarrhea)	☐ Sore throat spray	☐ Insect repellent/Bug Spray
☐ Immodium (for diarrhea)	☐ Diphenhydramine antihistamine/allergy medicine	☐ Aloe gel or cream (for sunburn)
☐ Laxative (for constipation – i.e. Ex-Lax)	(i.e. Benadryl)	☐ Calamine Lotion

Comments:

I give permission for UME-designated Camp Health Supervisor/Monitor to administer the medications and remedies listed above. I understand the medications/remedies maintained at the Camp Health Center are only for one-time or limited-time use, and will not be provided to my Camper on a long-term or continuing basis. I understand the medications/remedies will be administered according to label directions unless I specifically directed otherwise in the "Comments" section above.

Signature of Parent/Guardian: _____ **Date:** _____ **Relationship to Camper:** _____

Camper's Name: _____
Age: _____ Birthdate: _____

MEDICATION ADMINISTRATION AUTHORIZATION FORM
MARYLAND 4-H CAMPS

This form must be FULLY completed and signed by both the Camper's Parent/Guardian and Physician for Camp Staff members to administer the required medication, or for the Camper to self-administer medication. A new Medication Administration Authorization Form must be completed at the beginning of each camp season, or any time there is a change in dosage, use, or administration of a medication. Unless updated sooner, this form is valid for one year from the date of Physician's signature. All medications or substances authorized by this form must be handled as follows:

- **Prescription medications** must be in original pharmacy container, labeled with the Camper's name, name of medication, dosage, frequency of administration, prescription number, and prescribing physician's name and phone number. Medication label information must match the information and instructions provided on this form.
- **Non-prescription medications, vitamins, and supplements** must be in original container with instructions for use on label.
- Containers must contain **exactly enough** medication for Camper's use during scheduled duration of the Camp **(NO "extras")**
- An **adult must bring the medication to Camp** and give the medications to an adult staff member. Multiple medication containers for one Camper should be collected in a clear plastic bag labeled with the Camper's name.
- Campers who are **authorized to self-carry/self-administer medication** (such as inhaler, insulin, Epi-pen, etc) may carry the medication to Camp but must, in the presence of a responsible adult, show it to an adult Camp Staff member when checking in

CAMPER TAKES THE FOLLOWING MEDICATIONS ON A DAILY OR ROUTINE AS-NEEDED BASIS:

(Include all prescription medications and non-prescription medications, vitamins, supplements, etc. supplied by the Camper)

Name of Medication	Dates Taken	Reason for Taking	Times Taken & Dosage	Route (oral, topical, etc)	Special Instructions/Side effects *Note if Emergency Medication	Can Camper Self-Administer? *(see reverse for policy)*

Copy this page if more space is needed. Physician must sign EACH PAGE listing medications.

Physician's Signature

Physician's Name/Title

Physician's Phone

Date Signed

Physician's Address Stamp

OVER - Additional signatures required on reverse

Camper's Name: _____
Age: _____ Birthdate: _____

MEDICATION AUTHORIZATION: I request the authorized Camp Staff to administer medication or supervise the Camper in self-administration if authorized, as prescribed by the Physician. I certify that I have legal authority to consent to medical treatment for the Camper named above, including the authority to consent to administration of medication. I understand that my camper should bring EXACTLY the amount each medication required for the duration of the Camp, in properly-labeled containers. However, further I understand that if any medication remains at the end of the authorized period it must be picked up by an adult, otherwise it will be discarded. I authorize Camp personnel to communicate with the prescriber as allowed by HIPAA.

Signature of Parent/Guardian: _____ **Date:** _____ **Relationship to Camper:** _____

AUTHORIZATION FOR SELF-ADMINISTRATION / SELF-CARRY MEDICATIONS

This section should be completed if medication is approved for self-administration and/or self-carry by the Camper under supervision of a Camp Staff member. **"Self-administration"** means the Camper is able to take/apply the medication without assistance, but under supervision of a Camp Staff member. **"Self-carry"** means the Camper may carry the medication with him/her during Camp activities. Self-carry of medication by Campers is permitted only for emergency medications such as inhalers, insulin, epinephrine, etc. Unless noted as "self-carry," all self-administered medications will remain under control of Camp Staff designee and dispensed according to the listed schedule.

All self-administered and self-carry medication must be listed on the reverse of this form. **Both the Physician and the Parent/Guardian must consent** to self-administration and/or self-carry by the Camper**.** However, Maryland youth camp operators are not required to permit self-administration or self-carry by Campers.

AUTHORIZATION: I consent that the Camper named above is able to self-administer the medication(s) as listed on the reverse of this form. I authorize self-administration of the listed medication(s) by the Camper under the supervision of an authorized Camp Staff member. If indicated below, the Camper may self-carry emergency medication and self-administer as necessary.

Emergency medication(s) authorized for SELF-CARRY by Camper (must also be listed on reverse of this form)**:**

Signature of Parent/Guardian: _____ **Date:** _____ **Relationship to Camper:** _____

PHYSICIAN AUTHORIZATION

_____
Physician's Signature

_____
Physician's Name/Title

_____ _____
Physician's Phone **Date Signed**

Physician's Address Stamp