MARYLAND 4-H CAMPS
HEALTH FORM

Current Photo Of Camper

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

☐ Male
☐ Female

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

Dates will attend Camp:
_____ to _____
MM/DD/YYYY *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 To be Notified in case of Injury or Illness:

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

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

SECOND PARENT/GUARDIAN Or other Emergency Contact:

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

ADDITIONAL CONTACT in event parent(s)/guardian(s) cannot be reached:

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

HEALTH CARE PROVIDER CONTACTS

	Name:	Phone:
Primary Care Physician:	_____	_____
Dentist:	_____	_____
Orthodontist:	_____	_____
Other Provider (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 back of form 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: _____

❀ CAMPER HEALTH HISTORY Page 1

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

IMMUNIZATION CERTIFICATION:

State in which camper resides/attends school: _____

Date of last Tetanus immunization: _____

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

I certify my child has received and is up-to-date on all immunizations required for school attendance in the state where s/he lives/attends. 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.

MEDICATION:

☐ Camper will NOT take daily medications while attending camp.
☐ Camper WILL take the following daily medication(s) while attending camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins and natural remedies. Please list ALL medications the camper routinely takes. Attach additional pages is needed to list all medications. Bring exactly enough medication to last for the camp's duration. Bring medication to camp in the ORIGINAL container, which identifies the name of the medication, its dosage, frequency of administration, prescription number, and prescribing physician's name and phone number.

Name of Medication	Date Started	Reason for Taking	When Given	Amount/dose	How is it given? (orally, topically, etc)
			☐ Breakfast ☐ Dinner ☐ Lunch ☐ Bedtime ☐ Other: _____		
			☐ Breakfast ☐ Dinner ☐ Lunch ☐ Bedtime ☐ Other: _____		
			☐ Breakfast ☐ Dinner ☐ Lunch ☐ Bedtime ☐ Other: _____		
			☐ Breakfast ☐ Dinner ☐ Lunch ☐ Bedtime ☐ Other: _____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. Dosages will be administered according to directions on the container unless written direction by a physician is provided by the parent/guardian for alternative use. Check the boxes to select which medications may be administered to your camper.

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

I give permission for UME-designated Camp Health Supervisor/Monitor to administer the medications listed above, including the indicated non-prescription medications.

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

❀ CAMPER HEALTH HISTORY Page 2

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

ALLERGIES: ☐ No known allergies ☐ Allergic to: Foods Medicines Environment Other
(Circle all that apply & describe below. Attach additional pages if necessary)

What is camper allergic to? (Specific)	What is the typical reaction seen?	What is treatment is 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? ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc)
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. The camp may contact you for additional information.

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 PARTICIPTION AND RELEASE: 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: _____
(over 18 years of age)