

CENTRAL ILLINOIS 4H CAMP ASSOCIATION HEALTH HISTORY

This form must be completed for each child by the parent/guardian. This information will be kept confidential and used only for the welfare of your child.

Please circle: Male Female Date of Birth _____ Dates of Camp Program _____

CAMPER'S NAME _____
 (First) (Last)

Physician's Name _____ Phone _____

-----Instructions for Medications-----

1. All prescription drugs or over the counter medications you are presently taking **MUST** be carried in the container in which they were issued (with medical orders and physician's name intact), and given to the nurse/health director. Others will not be accepted.
2. If you need over-the-counter medications not listed below, they must be in the original container (no loose pills or pill boxes) and must be stored under lock and key by the nurse/health director or a responsible adult during the 4-H event.

Check Over-the-Counter Medications That Your Child May Receive if Deemed Necessary:

	Antiseptics		Diarrhea medication		Robitussin cough syrup
	Benadryl		Non aspirin pain medication		Sudafed

List Approximate Date if Your Child Has Had or Been Exposed to:

Chicken Pox _____ Tuberculosis _____ Measles _____ Mumps _____ German Measles _____

Last Booster: Tetanus _____ Polio _____

Check Below if Your Child is Subject To:

	Asthma, controlled? Y N		Convulsions/seizures		Fainting		Sinusitis
	Bedwetting		Cramps		Headaches		Sleepwalking
	Bronchitis		Diarrhea		Heart condition(s)		Other, please specify
	Constipation		Ear infections		Kidney problems		

Please list any medical conditions or diagnosis _____

Please List Your Child's Allergies (If none, please indicate with N/A) :

Food Allergies (specify) _____

Allergies to Medications: Prescription or non-prescription drugs (specify) _____

Serious Ivy, Oak, or Sumac Poisoning _____ Bee or Insect Stings _____ Prescribed Treatment _____

Please List Your Child's Medication(s) That Will be Brought to Camp (If none, please indicate with N/A) :

Name of Medication(s): _____

Dosage(s) _____

Circle Time(s) When Medication(s) Need(s) to be Administered: 8 am Noon 6 pm 9 pm Other _____

To the best of my knowledge my child's health history is as indicated and he/she may participate in an active camp program except as noted. **Authorization for treatment:** I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me or my child. In the event I cannot be reached in emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above and understand that the accident/illness insurance coverage does not cover pre-existing conditions. I give permission for my child to participate in all camp activities including swimming, boating, climbing, team challenge course, archery, and out of camp travel into adjacent Robert Allerton Park when it is a part of the camp program. This child may appear in pictures for publicity purposes for 4-H Memorial Camp. I understand my child will be informed of the camp's code of conduct and that I will be notified to come and get my child if he/she shows a blatant disregard for these rules.

PARENT'S NAME (Please Print Legibly) _____

SIGNATURE OF PARENT/GUARDIAN (mandatory) _____ **Date** _____