LOUISIANA 4-H YOUTH DEVELOPMENT PROGRAM

Day Camp Participant Medical Information Form

This medical form is for use with 4-H day camp and day events which do not include high impact experiences, over night lodging, or long distance transportation.

CAMPERS FULL NAME ____________ ____________ ____________

FIRST MIDDLE LAST

____________ ____________ ____________

ADDRESS STATE ZIP

____________ ____________ ____________

BIRTHDATE (00/00/0000) AGE GENDER

____________ ____________ ____________

PARENT/GUARDIAN'S NAME PARENT PHONE NUMBER #1 PARENT PHONE NUMBER #2

____________ ____________ ____________

EMERGENCY CONTACT NAME IF PARENT NOT AVAILABLE EMERGENCY CONTACT PHONE #1 EMERGENCY CONTACT PHONE #2

____________ ____________ ____________

PHYSICIAN'S NAME PHYSICIAN'S PHONE NUMBER HEATLH INSURANCE COMPANY NAME

ARE IMMUNIZATIONS CURRENT? ____________

____________ ____________

INSURANCE POLICY # NAME OF MEMBER

DATE OF LAST TETANUS SHOT? ____________

TO THE BEST OF MY KNOWLEDGE, THIS CHILD IS HEALTHY AND FIT FOR AN ACTIVE CAMP PROGRAM. ____________

HAS YOUR CHILD BEEN EXPOSED TO ANY COMMUNICABLE DISEASE IN THE PAST 6 MONTHS? ____________ IF YES, PLEASE EXPLAIN BELOW:

____

____________ ____________

PREVIOUS HOSPITALIZATIONS/SURGERIES LIMITATIONS OF ACTIVITIES BY PHYSICIAN'S ADVICE (IE SWIMMING, HIKING)

THE CAMPER IS CURRENTLY EXPERIENCING OR HAS RECENTLY HAD PROBLEMS WITH:

ALLERGIES

- ☐ HAY FEVER
- ☐ IVY POISONING, ETC
- ☐ PENICILLIN
- ☐ INSECT/BEE STINGS
- ☐ ASTHMA
- ☐ OTHER DRUGS
- ☐ OTHER (PLEASE SPECIFY) ____________

OTHER

- ☐ FREQUENT EAR INFECTION
- ☐ CONVULSIONS
- ☐ DIABETES
- ☐ BLEEDING/CLOTTING DISORDERS
- ☐ EXPOSURE TO SUN
- ☐ OTHER (PLEASE SPECIFY): ____________

NEURO/PSYCHOLOGICAL

- ☐ ADD/ADHD
- ☐ EPILEPSY
- ☐ CONCUSSION
- ☐ COUNSELING
- ☐ OTHER (PLEASE SPECIFY) ____________

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IS CAMPER ON RESTRICTED DIET? ______________ IF RESTRICTED DIET, PLEASE EXPLAIN DIETARY ISSUES AND NEEDS BELOW:

____

PLEASE NOTE: CAMPERS WITH SEVERE FOOD ALLERGIES OR UNIQUE DIETARY NEEDS ARE EXPECTED TO BRING THEIR OWN FOOD. FOOD WILL BE SAFELY STORED BY CAMP HOST.
WE CANNOT GUARANTEE THAT ANY AREA AT CAMP IS ALLERGEN-FREE!

MEDICATION INFORMATION

____
TYPE OF MEDICATION(S)

____
HOW TO ADMINISTER?

____
PURPOSE OF MEDICATION(S)?

____
OTHER COMMENTS OF INFORMATION PERTAINING TO MEDICATION?

Please note that the medication must be in original container with the label still intact.

MEDICINE DISPERSMENT:
We are only able to administer emergency medications, specifically:
Epi-Pens, Benadryl (for anaphylactic allergies), and inhalers.

MEDICAL CONSENT/RELEASE

The health history is correct so far as I know, and the person described has permission to engage in all prescribed camp activities except as noted. In Case of Medical Emergency, if I cannot be contacted, I hereby give permission to a camp representative and the physician he/she selects to secure proper treatment, including: hospitalization, ordering injections, giving anesthesia, x-rays, routine tests, treatment, transporting of child, or performing operations as may be urgently necessary for this child and to release reports necessary for insurance purposes for my son/daughter noted above. This form may be copied for emergency purposes. I understand that every effort will be made to contact the camper's responsible parent or guardian. I further understand that if I do not have medical insurance that covers all costs, I will be responsible for such medical costs.

By my signature below, I agree to this statement and further affirm all information correct as well as all information is provided about my child to ensure a positive, safe, and enjoyable environment for them as well as other campers and camp staff/volunteers

____ ______________________________
SIGNATURE OF PARENT/GUARDIAN DATE