Sertoma Deaf Camp

in conjunction with the

NC Department of 4-H Youth Development

Health History and Custody Release Form

Camper Name: ____
Last Name *First Name* *Middle Initial*

Birth Date_____/______/___________ Age at Camp_______ Gender: ☐ Female ☐ Male Email: ______________________

Address: ____
Street *City* *State* *Zip Code*

Custodial Parent/Guardian Name: ______________________Phone: (____) ____________

Second Parent/Guardian or Emergency Name: ______________________

Address:______________________Phone: (____) ____________

If not available in an emergency, notify (Name): ______________________

Relationship:______________________Phone: (____) ____________

HEALTH HISTORY

The following information must be filled in by the parent/guardian, or adult camper or staff member. Update required annually. Health exam must be completed by an approved licensed medical personnel within 24 months of participation. 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.

Important – These boxes must be complete for attendance

Parent/Guardian Authorization: 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 medications, and seek emergency medical treatment including ordering x-rays or 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, or adult camper/staffer: ______________________

Printed Name: ______________________ Date:____________

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of minor or adult camper/staffer: ______________________ Date: ____________

MEDICATIONS

Please list **ALL** medications, even over-the-counter or nonprescription drugs, including Tylenol, Pepto-Bismol, Benadryl, etc. that may be taken. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if prescription drug), the name of medication, the dosage, and the frequency of administration.

☐ This person takes NO medications on a routine basis
☐ This person takes medications as follows:

Med#1______________ Reason ________ Dosage______ Time taken ________
Med#2______________ Reason ________ Dosage______ Time taken ________
Med#3______________ Reason ________ Dosage______ Time taken ________
Med#4______________ Reason ________ Dosage______ Time taken ________

This person may take the following medications as needed:
☐ Aspirin ☐ Tylenol ☐ Ibuprofen ☐ Benadryl ☐ Pepto-Bismol ☐ Other______________

Known allergies to foods, drugs, insect stings or bites, etc: ______________________

RESTRICTIONS - The following restrictions apply to this individual:

Dietary

☐ Does not eat red meat ☐ Does not eat pork ☐ Does not eat eggs
☐ Does not eat poultry ☐ Does not eat dairy products ☐ Does not eat peanut products
☐ Other (describe)____

Camp is full of challenge by choice activities including a number of physical and emotional challenges. Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary): ____

____

____

GENERAL QUESTIONS (Explain "yes" answers.)

Has/does the participant:

	Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Ever been dizzy/passed out during or after exercise?	☐	☐
11. Ever had seizures	☐	☐
12. Ever had chest pain during or after exercise?	☐	☐
13. Ever had high blood pressure?	☐	☐
14. Ever been diagnosed with a heart murmur?	☐	☐
15. Ever had back problems?	☐	☐
16. Ever had joint problems?	☐	☐
17. Have any skin problems?	☐	☐
18. Have diabetes?	☐	☐
19. Have asthma?	☐	☐
20. Had mononucleosis in the past 12 months?	☐	☐
21. Have problems sleepwalking?	☐	☐
22. Have a history of bed wetting?	☐	☐
23. Ever had an eating disorder?	☐	☐

Please explain "yes" answers, noting the number of the questions. ____

____

____

Special medical concerns or conditions that event supervisors should know about, including contagious illnesses, epilepsy, asthma, diabetes, previous injuries to bones/joints, etc: ____

____

Which of the following has the participant had?

☐ Measles
☐ Chicken pox
☐ German measles
☐ Mumps
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C

TB Mantoux Test Date of last test________________________
Result: ☐ Positive ☐ Negative

Please give dates of immunization for:
(Immunization records may be attached to this form)

Vaccine:	Dates: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	____	____	____	____
TD (tetanus/diptheria)	____	____	____	____
Tetanus	____	____	____	____
Polio	____	____	____	____
MMR	____	____		
or Measles	____	____		
or Mumps	____	____		
or Rubella	____	____		
Haemophilus influenza	____	____	____	____
Hepatitis B	____	____	____	
Varicella (chicken pox)	____	____	____	

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

____

____

____

Name of family physician: ____ Phone: (___) ____________

Address: ____
Street Address *City* *State* *Zip Code*

Name of family dentist/orthodontist: ____ Phone: (___) ____________

Address: ____
Street Address *City* *State* *Zip Code*

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on ____________________________. BP_____ Wt _____ Ht______

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.
Restrictions/Recommendations:____
____
____

Treatment to be continued at camp or medications to be administered at camp (name, dosage, frequency)
____
____

Additional information for health care staff at camp: ____
____
____

Signature of Licensed Medical Personnel:____Date:_________

Printed:____Title:___________________________

Address:____Phone: (___) ___________________

Street City State Zip Code

* * * *

This form will not be considered as complete without the signature above by a licensed medical personnel.

WE ARE AWARE THAT BETWEEN THE TIME YOU FILL THIS FORM OUT, AND THE FIRST DAY OF CAMP, SOME OF THE INFORMATION CONTAINED IN THIS DOCUMENT MAY HAVE CHANGED. PLEASE ADVISE THE REGISTRATION COORDINATOR OF ANY CHANGES TO HEALTH STATUS OR MEDICATIONS PRIOR TO THE FIRST DAY OF CAMP.

Screening Record: For camp use only Date___________ Time_________

Meds received____

Updates/additions to Health History____

Current Health needs identified____

Screened by____

Custody Release: You may be asked to produce photo ID at check-out. This is for your child's safety. Please be aware of this policy before picking up your child. I hereby give permission for my child, ______________________________, to be allowed to leave the 4-H Camp at the conclusion of the camping program. My child will be released into the custody of:

____
(Names of Individuals authorized to pick up your child)

If it is necessary for my child to leave the Camp before the end of the program due to illness, injury, or behavioral issues, and I cannot be reached, I hereby give permission for my child to be released into the custody of:

____
(Emergency contact or other individual authorized to pick up your child)

For Camp Use Only: Camper picked up by:_________________________________Staff Signature___________________

MEDICAL INFORMATION AND INFORMED CONSENT FOR TREATMENT

PLEASE READ AND COMPLETE THE FOLLOWING FORM. THIS FORM MUST HAVE A NOTARIZED SIGNATURE.

I. Medical Information (Pages 1-3 of this document)

II. Insurance Information

The Sertoma Deaf Camp, in conjunction with the 4-H program, purchases insurance for youth participants for many sponsored events. In some cases, this coverage will not pay for some medical expenses and it may be necessary to bill the family or your insurance company.

Health Insurance Company ____

Health Insurance Policy # ____

Company Address ____

Company Telephone Number (______)____

III. Informed Consent

In the event that a participant needs minor medical care from Sertoma Deaf Camp/4-H or more significant medical care from a qualified health care provider, including in rare cases possible hospitalization and/or surgery, the parent/guardian is asked to sign the informed consent form below. In case of serious medical condition, Sertoma Deaf Camp/4-H will make every effort to notify the parents, but the first priority may be providing care to the participant.

Authorization to Consent to Health Care for Minor

I, ____, of _________________County, am the custodial parent

having legal custody of ___________________________________, a minor child, age _______, born,
(Name of youth participant)

____________________________. I authorize any adult(s) acting as agents (including official volunteers)
(Youth participant birth date)
or employees or volunteers of the 4-H program/Sertoma Deaf Camp planning committee, and in whose care the minor child has been entrusted, to do any acts which may be necessary or proper for the health care of the minor child including, but not limited to, the power (1) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (2) to consent to and authorize any health care including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining, procedures.

This consent shall be effective for one year from the date of execution.

Custodial Parent Signature ____Date________________
Please sign on the above line in front of a Notary Public, who will provide witness below.

Notary Public:

STATE OF ________________________, COUNTY OF ____________________, ss.:

On this day, personally appeared before me ____ (minor child's parent or legal guardian), to me known to be the person(s) described in and who executed the within and foregoing instrument, and acknowledged that he/she signed the same as his/her voluntary act and deed, for the uses and purposes therein mentioned. Witness my hand and official seal hereto affixed this ______ day of ____________, _________.

____
Notary Public in and for the State of _________________.
My commission expires _______________.

This form will not be considered as complete without the signature above by the camper's parent or legal guardian, as witnessed by a Notary Public.