

# Alabama 4-H Summer Camp Youth Health History Form

892 4-H Road, Columbiana, AL 35051  
Tel (205) 669-4241, Fax (205) 669-1364

All items on this form must be completely filled out. Please note the "Physician Referral" section must be completed by a physician/nurse practitioner. If this form is not completed in its entirety, the youth will not be able to participate in activities at the Alabama 4-H Center.

Camper's Name \_\_\_\_\_  
Last
First
Middle Initial

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Female Male  
Month / Day / Year

Program (please check appropriate boxes)      (a) Summer Camp Session       Session Number [1] [2] [3] [4] [5] [6]

Home Address \_\_\_\_\_  
Street
City
State
Zip

Home Phone \_\_\_\_\_

Parent/Guardian Work Phone \_\_\_\_\_

Family E-mail \_\_\_\_\_ Cell Phone \_\_\_\_\_

### EMERGENCY CONTACT

Primary Emergency Contact \_\_\_\_\_ (Relationship) \_\_\_\_\_

Phone Numbers \_\_\_\_\_

Alternate Emergency Contact \_\_\_\_\_ (Relationship) \_\_\_\_\_

Phone Numbers \_\_\_\_\_

### HEALTH HISTORY

Does the youth have – or has ever had -- any of the following? Check **Yes** or **No** to each item.  
 Reporting a health condition will not prevent a person from attending 4H Center activities and information is strictly confidential.

Health Condition	Yes	No	Health Condition	Yes	No
Asthma/other lung issues	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes/Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	ADD / ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infection	<input type="checkbox"/>	<input type="checkbox"/>	Wear Corrective Lenses	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>
List any allergies (food, environmental, medications) below:			Other Conditions	<input type="checkbox"/>	<input type="checkbox"/>

Please explain **Yes** answers and provide information on **present medications** (including herbals, homeopathic & over the counter), recent medical issues (including injuries and surgeries), allergic reactions, special dietary regulations, any specific activities to be restricted and other comments.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I am giving the 4H Center permission to administer these OTC (over-the-counter) medications that I am providing. I understand that the 4H Center and its staff does **NOT** stock and /or provide these OTC medications. As a parent/guardian, I will provide the required medications for the duration of my child's stay at camp as outlined in the Parent Packet (Over the Counter Medications Procedures).

- |                                                        |                                                                                                                  |                                       |                                         |
|--------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Antihistamine (Benadryl)      | <input type="checkbox"/> Ibuprofen (Advil)                                                                       | <input type="checkbox"/> Pepto-Bismol | <input type="checkbox"/> Baby Aspirin   |
| <input type="checkbox"/> Antacid                       | <input type="checkbox"/> Acetaminophen (Tylenol)                                                                 | <input type="checkbox"/> Decongestant | <input type="checkbox"/> Hydrocortisone |
| <input type="checkbox"/> Polysporin (antibiotic cream) | <input type="checkbox"/> <b>Please contact me for permission to administer any over-the-counter medications.</b> |                                       |                                         |

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#### IMMUNIZATION HISTORY

**\*\*Attach a copy of immunization record (blue form) including most recent tetanus shot. These MUST accompany the health forms\*\***

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#### INSURANCE INFORMATION

Youth's Doctor \_\_\_\_\_  
Phone \_\_\_\_\_  
Health Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Relationship to Participant \_\_\_\_\_  
Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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#### PERMISSION TO TREAT / TRANSPORT

I, \_\_\_\_\_ (parent/guardian) hereby give permission to the Alabama 4H Center and its staff to treat my child for injuries as needed. I understand that Alabama 4H Program Staff is certified as a minimum, in First Aid and CPR. I also understand there is a full time nurse on site. In the unlikely event of an emergency, I give permission to Alabama 4H, its staff and the nurse on site to transport my child to a medical facility if necessary (hospital, clinic, etc.) Furthermore I give permission to the nurse on site to dispense/administer medications brought to camp by parent/guardian for my child, or prescribed by a physician while attending camp.

[If, for religious reasons, you cannot sign this section, please contact 4-H personnel]

Camper Name \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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#### LIABILITY RELEASE

I hereby agree that I understand the risks or have been given the opportunity to ask for information concerning risks involved in this activity and assume all risks and release Alabama 4-H Center, the Alabama Cooperative Extension System, local Extension offices, Auburn University, Alabama A & M University, the State of Alabama, the Alabama 4-H Foundation and 4-H Youth Development Center, and their trustees, agents, officers and employees, from all claims, demands, and causes of action of any kind, including claims of negligence, which may arise from participation of me or my minor child in any Alabama 4-H sponsored activity, and this release is specifically granted in consideration of the services, programs and activities.

Camper Name \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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## PHYSICIAN REFERRAL

(\*\*\*to be completed by a physician/nurse practitioner\*\*\*)

Camper Name: \_\_\_\_\_ Summer Camp Session \_\_\_\_\_

Date of last physical exam (must be within past 24months) \_\_\_\_/\_\_\_\_/\_\_\_\_

Description of any camp activity (i.e. climbing wall, high ropes elements, swimming, caving, hiking, general spots activities) from which camper should be exempted due to health reasons/limitations

In my professional opinion, this individual,

\_\_\_\_\_ Should be allowed to participate in an active camp program at the Alabama 4 H Center

\_\_\_\_\_ Should NOT be allowed to participate in an active camp program at Alabama 4 H Center

This camper is under my care for the following condition(s):

\_\_\_\_\_  
\_\_\_\_\_

Treatment to be continued at camp:

\_\_\_\_\_  
\_\_\_\_\_

Medications to be administered at camp (name, dosage, frequency) including OTC medications

\_\_\_\_\_  
\_\_\_\_\_

Medically prescribed meal or dietary restrictions

\_\_\_\_\_  
\_\_\_\_\_

Known allergies (food, environmental, medications)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

Date of recent tetanus shot \_\_\_\_\_

Printed Name (of physician / nurse practitioner) \_\_\_\_\_

Title \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

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