

4-H Cloverbud Camp - Clinton County  
"The Animal Kingdom"

June 2, 2008

9:30 a.m. - 3:30 p.m.

Personal Health and Registration Form

Office Use Only: Payment \_\_\_\_\_

**Identification:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Age \_\_\_\_ Sex \_\_\_\_ School grade completed \_\_\_\_ Please circle a Youth T-shirt size: S, M, L, XL  
Name of parent or guardian \_\_\_\_\_ Home Phone \_\_\_\_\_ Work phone \_\_\_\_\_  
Address: \_\_\_\_\_

**Camp Fees:** \$25 4-H Cloverbud and non-members due May 16 - no late registrations accepted

- Make check payable to "OSU Extension Office."
- Camp scholarships are available in the Extension office or on <http://clinton.osu.edu>

**Return the registration & health form by May 16 to:**

OSU Extension, 111 S. Nelson Avenue, Suite 2, Wilmington, OH 45177, (937) 382-0901.

- ✦ Bag with identification
- ✦ Medications and doctor's signature if needed
- ✦ Water bottle with identification
- ✦ Wear play clothes—jeans, t-shirts, shorts, etc.
- ✦ Tennis shoes - No flip flops!
- ✦ Jacket & Rain Coat
- ✦ Insect Repellent
- ✦ Sunscreen
- ✦ Camp themed clothing and items

**Emergency Information:**

If unable to reach parent or guardian in the event of an emergency, please notify:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Name of personal physician \_\_\_\_\_ Phone \_\_\_\_\_  
Name of personal dentist \_\_\_\_\_ Phone \_\_\_\_\_

**Medical Information:**

In the event of an emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the camp director in charge, to hospitalize, secure proper treatment for and to order injections, anesthesia, and or surgery for my child, as named above.

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

1. Has your child had an illness or injury within the last 6 months that limited activity for longer than one week?

Yes \_\_\_ No (If you check "yes" please schedule an appointment with your physician for an updated medical evaluation. Please provide a statement from your physician).

1. Has your child lost consciousness in the past 12 months during physical activity or had a concussion due to a head injury? \_\_\_ Yes \_\_\_ No (If you check "yes" please provide a current statement from your physician on the nature and extent of current symptoms).

2. Is your child currently being treated by a physician? \_\_\_ Yes \_\_\_ No (If you check "yes" please provide a statement from your physician indicating what current treatment is being given).

1. Is your child on a medically prescribed meal plan? \_\_\_ Yes \_\_\_ No (If you check "yes" please provide a copy of

your child's diet to assist our cooks in preparing meals to meet his/her needs).

1. Is there any reason to restrict full activity, including swimming, long hikes, strenuous physical games?  Yes  
 No List any conditions limiting full participation (physical or emotional).

**Immunizations:** Date of last inoculations (Indicate month and year): Tetanus \_\_\_\_\_ Toxoid \_\_\_\_\_

Polio \_\_\_\_\_ Mumps \_\_\_\_\_ Diphtheria \_\_\_\_\_ Pertussis \_\_\_\_\_ Measles \_\_\_\_\_ Rubella \_\_\_\_\_

\* Please note: If your child has not had a tetanus shot in the past 10 years, please schedule an appointment with your physician for your child to receive a tetanus inoculation (or booster) at least two weeks before they attend camp.

**Medications:**

Is your child taking any medication regularly?  Yes  No (If you check "yes" a medication release form must be completed including the doctor's signature. No medication will be given without this completed form. The completed medication release form must accompany your child to camp.)

List all medications your child needs to be given while at camp. Send ample supplies in original (child proof) containers with an affixed label including camper's name, name of medication, dosage, method and time of administration. This also includes over the counter medications such as Aspirin, Tylenol, etc. \_\_\_\_\_

**Allergies:**

Any medicines?  Yes  No Food  Yes  No Plants  Yes  No Insect bites  Yes  No

Explanations: \_\_\_\_\_  
\_\_\_\_\_

**Health History (Past and Present) Please check:**

Asthma  Yes  No Bedwetting  Yes  No Cancer  Yes  No Convulsions  Yes  No

Diabetes  Yes  No Fainting  Yes  No Heart Disease  Yes  No Hemophilia  Yes  No

Kidney Disease  Yes  No Leukemia  Yes  No Sleepwalking  Yes  No

Explanations: \_\_\_\_\_  
\_\_\_\_\_

Does your child have any special equipment such as orthopedic or handicap devices, glasses, contacts, dentures, retainers?  Yes  No If so please list them: \_\_\_\_\_

How did you hear about 4-H Cloverbud Camp?

Check all that apply.

\_\_\_\_\_ Newsletter

\_\_\_\_\_ Newspaper

\_\_\_\_\_ Flyer mailed to my home

\_\_\_\_\_ Flyer picked in a business

\_\_\_\_\_ 4-H Club Meeting

\_\_\_\_\_ Other, please explain

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