

4-H Cloverbud Camp - Clinton County
"Splish - Splash Let's Have A Blast
June 15, 2012
9:00 a.m. - 4:30 p.m.
Personal Health and Registration Form

Office Use Only: Payment

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 June 1 (including t-shirt). Late camp registrations will be accepted from June 2 - June 11 for \$30. Late registrations will not receive a t-shirt.

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

Return the registration & health form by June 1 to:

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

What to pack:

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

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 _____

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 _____

Name of personal dentist _____ Phone _____

Medical Information:

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).

2. 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).

3. 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).

4. 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).

5. 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: _____

I am of the opinion that _____ can participate in the **2012 Clinton County Cloverbud Camp June 15, 2012**. I further declare that he/she has no physical, mental, or communicable conditions that will interfere with participation in this program. I consider his/her health to be:

Poor

Fair

Good

Excellent

Signature of Parent/Guardian _____ Date _____

Allergies:

Any medicines? ___Yes ___No Food ___Yes ___No Plants ___Yes ___No Insect bites ___Yes ___No

Explanations: _____

How did you hear about 4-H Cloverbud Camp?

Check all that apply.

_____ Newsletter

_____ Flyer mailed to my home

_____ 4-H Club Meeting

_____ Newspaper

_____ Flyer picked in a business

_____ Other, please explain _____