

NC Department of 4H Youth Development

Health History and Custody Release

Name _____ Birth Date _____ Age at Camp _____ Gender _____
Last First Middle

Home Address _____ County _____
Street City State Zip

Emergency Contact (Other than Parent/Guardian) Name _____ 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.

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 Ibuprofin Benadryl Pepto-Bismol Other _____

General Questions (Explain "yes" answers.)

Has/does the participant:

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

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

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:

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

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:

Signature of Licensed Medical Personnel _____ **Date** _____

Printed _____ Title _____

Address _____ Phone _____

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 can not 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 _____.