The North Carolina State Grange

TO: **Grange Camp Participants and Parents**
FROM: **Jennie Gentry, State Youth Director**
RE: **Camp Health Form Instructions**

We are extremely excited that you are able to attend 2016 Grange Camp!

Each camper must submit the enclosed Camp Health Form to the NC State Grange to be able to participate in camp. Because it is the most detailed form, below are instructions to assure that you have completed the form correctly.

COMPLETING THE CAMP HEALTH FORM

All 4 pages of the health form must be completed, even if you are submitting a copy of a physical. The list below includes items that are extremely important to complete the form. These are items that are sometimes overlooked or most often asked about.

PAGE 1: ___ Need parent AND camper signature in the box in middle of the page.
PAGE 2: ___ Immunizations can be written in or you can attach a copy of immunization records.
___ Must have a doctor signature (bottom) or a copy of a physical that has been completed in past 2 years.
PAGE 3: ___ Please complete the Custody Release at the top of the page. (Campers riding the bus can put "Grange Bus" for who you are departing camp with. However, please do list any persons with permission to pick up the camper should they have to leave camp early.)
___ Must have parent AND camper signature at the bottom of page 3.
Page 4: ___ If the camper is under the age of 18, then Page 4 MUST be notarized.
___ Make a copy of the completed form! (Just in case we need you to resubmit it, or if you need it for future years of Grange Camp.)

SUBMITTING THE FORM

Please submit the form BY JUNE 15 to the NC State Grange by fax, email or mail to the information below:

Email: jenniegentry@ncgrange.com (preferred method)
Fax: 704-878-9460
Mail: Jennie Gentry
NC State Grange
1734 Wilkesboro Hwy
Statesville, NC 28625

Please contact me at 919-744-7434 or jenniegentry@ncgrange.com with any questions. Thank you!

JRG

NC Department of 4H Youth Development
Health History and Custody Release

4-H Group / County: _____ **Year:** _____

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*

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_____

4-H MEDICAL INFORMATION AND INFORMED CONSENT FOR TREATMENT FOR NC 4-H SPONSORED EVENTS

PLEASE READ AND COMPLETE THE FOLLOWING FORM. THIS FORM MUST HAVE A NOTARIZED SIGNATURE AND BE PRESENTED AT THE OFFICIAL REGISTRATION FOR THE 4-H SPONSORED EVENT BEING ATTENDED.

I. Medical Information (Pages 1 and 2)

II. Insurance Information

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. Disability Assistance

If you are a person with a disability and desire any assistive devices, services, or other accommodations to participate in this activity, please contact the offices of the Eastern 4-H Center at (252) 797-4800 during business hours of 8:00a.m. to 5:00p.m. to discuss accommodations at least one business week prior to activity.

Signatures Acknowledging Parts I, II, III

Parent's/Guardian's Signature _____Date:_____

Participant's Signature: _____Date: _____

Parent/Guardian telephone #: Home: (____)_____Work: (____)_____

IV. Informed Consent

In the event that a participant needs minor medical care from 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, 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 4-H youth participant)

_____. I authorize any adult(s) acting as agents (including official volunteers)
(Youth participant birth date)
or employees of the 4-H program 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_____

STATE OF NORTH CAROLINA
COUNTY OF _____

On this _____day of _____ (*month*),_____ (*year*),

_____ personally appeared before me the named,

_____, to me known and
(Parent/Guardian)
known to me to be the person described in and who executed the foregoing instrument and he (or she) acknowledged that he (or she) executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

My Commission Expires: _____, 20____

_____, *Notary Public*
Signature

_____
Printed Name

(OFFICIAL SEAL).