

TO: Grange Camp Participants and Parents / Guardians

FROM: Jennie Gentry, State Youth Director RE: Camp Health Form Instructions

We are extremely excited that you are able to attend 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. Please follow these guidelines very closely.

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.

PAGE 1: _	Need parent AND camper signature in the boxes in middle of the page.
	 Immunizations can be written in or you can attach a copy of immunization records. Must have a doctor signature (bottom) OR you can attach a copy of a physical that has been completed by a healthcare professional within the 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.
•	 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.)
Em	AG THE FORM: Please submit the form BY JUNE 15 to Jennie Gentry in one of these 3 ways: ail: jenniegentry@ncgrange.com c: 704-878-9460

Mail: Jennie Gentry
NC State Grange
1734 Wilkesboro Hwy
Statesville, NC 28625

Please contact Jennie 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:	GRANGE		Year: <u>202</u>	0	Provided Linder Statute Conf
Camper Name:	and Maria	Circl Nove o		Middle le	:4:-1
Birth Date//	Age at Camp Ge	First Name ender: □ Female □ N	lale Email:	Middle In	
Address:Street					
	·			State	Zip Code
	e:			Phone: (_)
Second Parent/Guardian or Em	ergency Name:				
Address:				Phone: (_)
f not available in an emergency	, notify (Name):				
Relationship:				Phone: (_)
completed by an approved lice personnel the background to p provided to camp health person	be filled in by the parent/guardia nsed medical personnel within 24 rovide appropriate care. Keep a nel upon participant's arrival in ca nportant – These box	months of participation copy of the complete complete mp. Provide complete	on. The intent of the form for your reinformation so the	his information is to ecords. Any chan at the camp can be	provide camp health ca ges to this form should
activities except as noted. I hereby give permission to the c x-rays or routine tests. I agree to arrange necessary related transpln the event I cannot be reached hospitalization, for the person na	in an emergency, I hereby give perm med above. This completed form ma	dminister prescribed med for treatment, referral, but ission to the physician set by be photocopied for trip	lications, and seek e illing or insurance p elected by the camp s out of camp.	emergency medical truiposes. I give perminate to secure and admini	eatment including ordering ssion to the camp to
	adult camper/staffer:				
Printed Name:				Date:	
I also understand and agree to a	bide by any restrictions placed on my	participation in camp ac	tivities.		
Signature of minor or adult camp	er/staffer:			Date:	
enough medication to last the e he name of medication, the dos □ This person takes NO medic □ This person takes medication	ns as follows:	original packaging/bo stration.	ttle that identifies	the prescribing phy	sician (if prescription dru
	Reason	=			
Med#2				n	
	Reason	_			
This person may take the follow ☐ Aspirin ☐ Tylenol	•	Dosage nadryl □ Pept		Other	
Known allergies to foods, dru	igs, insect stings or bites, etc:				
Restrictions - The follow Dietary Does not eat red meat Does not eat poultry Other (describe)	ving restrictions apply to this ☐ Does not ea ☐ Does not ea	t pork		es not eat eggs es not eat peanut p	products
Camp is full of challenge by cho	ice activities including a number on sor limitations are necessary): _				

General Questions (Explain "yes" answers.)	Van Na		V N.
Has/does the participant: 1. Had any recent injury, illness or infectious disease?	Yes No □ □	13. Ever had high blood pressure?	Yes No
Have a chronic or recurring illness/condition?		13. Ever nau night blood pressure?	
3. Ever been hospitalized?		14. Ever been diagnosed with a heart murmur?	
4. Ever had surgery?		15. Ever had back problems?	
5. Have frequent headaches? 6. Ever had a head injury?		16. Ever had joint problems? 17. Have any skin problems?	
7. Ever been knocked unconscious?		18. Have diabetes?	
Wear glasses, contacts or protective eye wear?		19. Have asthma?	
9. Ever had frequent ear infections?		20. Had mononucleosis in the past 12 months?	
10. Ever been dizzy/passed out during or after exercise?		21. Have problems sleepwalking?	
11. Ever had seizures		22. Have a history of bed wetting?23. Ever had an eating disorder?	
12. Ever had chest pain during or after exercise? Please explain "yes" answers, noting the numbe			
Special medical concerns or conditions that event previous injuries to bones/joints, etc:		now about, including contagious illnesses, epilepsy,	asthma, diabetes,
Which of the following has the participant had?		Please give dates of immunization for:	
☐ Measles		(Immunization records may be attached to th	is form)
☐ Chicken pox		Vaccine: Dates: Mo/Yr Mo/Yr Mo/Yr	
☐ German measles		DTP	
☐ Mumps		TD (tetanus/diptheria)	
☐ Hepatitis A		Tetanus	
☐ Hepatitis B		Polio	
☐ Hepatitis C		MMR	
			
TB Mantoux Test Date of last test		or Measles	
Result: Positive Negative		or Mumps	
•		or Rubella	
		Haemophilus influenza	
		Hepatitis B	_
		Varicella (chicken pox)	_
the camp should be made aware.		pant's behavior and physical, emotional or mental	
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 \square is \square is no	able to participate		
Restrictions/Recommendations:			
TAGSUTCHOUS/TAGCOTHITICHUADIONS.			
Treatment to be continued at camp or med	ications to be admi	nistered at camp (name, dosage, frequency)	
•		3,	
A-LPC	. (
Additional information for health care staff	at camp:		
			_
Signature of Licensed Medical Personne	el:		Date:
Printed:		Title:	
' -			
Address: City	State 7:- 0	Phone: ()	
Street City	State Zip Co	u c	2 6 4

Screening Record: I	For camp use only	Date	Time
	Health History		
	identified		
Screened by			
Custody Rel before picking up you at the conclusion of the	r child. I hereby give permission for my child ne camping program. My child will be release	d,ed into the custody of:	or your child's safety. Please be aware of this policy, to be allowed to leave the 4-H Cam
	(Names of Individuals authorized		
	ny child to leave the Camp before the end of ion for my child to be released into the custo		injury, or behavioral issues, and I cannot be reache
	(Emergency contact or other ind	ividual authorized to pick up your	child)
For Camp Use Only	Camper picked up by:		Staff Signature
\$\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	4-H MEDICAL INFORMATION TREATMENT FOR N		
The 4-H pr cases, this c	ogram purchases insurance for y		or many sponsored events. In some it may be necessary to bill the family
•	rance Company		
	rance Policy #		<u> </u>
Company A			
	·		
III. Disability A If you are accommoda (252) 797-4	ssistance a person with a disability a attions to participate in this activity	nd desire any ass	istive devices, services, or other offices of the Eastern 4-H Center at to discuss accommodations at least
Signatuı	es Acknowledging Part	s I, II, III	
Parent's/Gu	ardian's Signature		Date:
Participant'	s Signature:		Date:
Parent/Guar	rdian telephone #: Home: ()	W	ork: ()

IV. <u>Informed Consent</u>

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.

1,	, of	County, am t	he custodial	parent
having legal custody of(Name		, a minor chil	ld, age	, born,
(Nam	e of 4-H youth participant)		_	
	for the health care of the min health care at any hospital or her person whose services ma any health care including erations, and other procedure holding or withdrawal of life so one year from the date of exec	hild has been ended controlled included other institution by be needed for administration as by physician staining, procesution.	ntrusted, to ding, but not n, or the em r such health of anesthens, dentists, dures.	lo any act limited to ploying on care, and sia, X-ra and othe
On thisday of				
(Parent/Gua known to me to be the person descr acknowledged that he (or she) exec statements in the foregoing instrum	ribed in and who executed the cuted the same and being duly	foregoing instru	ument and he	
y Commission Expires:		, 20		
			, Notary	Public
				
	Signature			