CONFIDENTIAL

PARTICIPANT HEALTH HISTORY FORM

This form must be completed for each child by the parent/guardian and information will be kept confidential for the child's welfare.

Please circle: Male Female Date of Birth_____ Dates of Camp Program _____

CAMPER'S NAME _____
(First) (Last)

Parent/Guaridan Name_____ Phone_____ Cell Phone_____

ALL medications, prescription and non-prescription, MUST be in the original container in which they were issued (with medical orders and physician's name intact), and given to the nurse/health director during camp session.

Check Over-the-Counter Medications That Your Child May Receive if Deemed Necessary:

	Antiseptics		*Diarrhea medication*		*Antibiotic Ointment*
	Benadryl		*Non aspirin pain medication*		

Is this camper current on immunizations required to attend school in Illinois?
YES_____ or NO_____ If no, please explain_____

Last Booster: Tetanus_____

Check Below if Your Child is Subject To:

	Lung Disease (asthma or tuberculosis)		Heart or Cardiac Condition		Kidney Problems
	Migraines		Sleep Walking		Nervous or Mental Conditions

DETAIL OF OTHER MEDICAL CONDITIONS:_____

History of ALLERGIES (check those that apply, then provide detail below)

	Bee Stings		Food Allergies
	Allergies to Medicine		Other Allergies

DETAIL OF ALLERGIES:_____

Please List Your Child's Medication(s) That Will be Brought to Camp (If none, please indicate with N/A) :

Name of Medication(s): _____
_____
_____

Dosage(s) _____

Circle Time(s) When Medication(s) Need(s) to be Administered: 8 am Noon 6 pm 9 pm Other _____

Illinois Extension
UNIVERSITY OF ILLINOIS URBANA-CHAMPAIGN

18 USC 707

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HEALTH INFORMATION STATEMENT

Check below any information you feel staff and/or volunteers may need, to maximize the safety and the well-being of the exhibitor or staff member. To the right of the condition statement is space for more information relating to the condition checked. Please be specific. In case of emergency, this health information may be the only source of accurate, important information.

[ ] Pain in Chest or Shortness of Breath (heart murmur, rheumatic fever) _____

_____

[ ] Stomach or Intestinal Trouble (ulcers, gall bladder or liver disorder, jaundice, hernia, colitis)

_____

[ ] Arthritis, Diabetes, Kidney or Bladder Disease _____

_____

[ ] Impaired Sight or Hearing, Chronic Ear Infections_____

_____

[ ] Recent Surgical Operation, Accidents or Injuries_____

_____

[ ] Any Infectious Disease_____

_____

[ ] Skin Disease_____

_____

[ ] Under on-going care of a Physician (NAME & PHONE #) for chronic or recurring problem

_____

[ ] Do you wear glasses? YES[ ] NO [ ] SOMETIMES [ ]

[ ] Do you wear contact lenses? YES [ ] NO [ ] SOMETIMES [ ]

[ ] Date of last FLU SHOT _____

[ ] Significant Orthopedic and/or Neuromuscular Impairment (e.g. loss of limb, spinal cord injury)

Primary Care Physician: _____

Clinic/Hospital Affiliation: _____

City: _____State: _____Phone: _(____)_____-_____

Health Insurance Provider: _____

Owner's Name: _____ ID/Policy Number: _____

Medical Privacy Statement: *It is the policy of University of Illinois Extension 4-H Youth Development Programs to keep any medical information it may have regarding 4-H Youth Development program participants confidential. However, there may be time in which such medical information will be needed and may need to be shared with others. Examples of sharing might include: providing information to medical personnel in the event of an emergency so that a youth may be treated; providing information to Extension staff or volunteers who are coordinating specific events in the case of a request for reasonable accommodation; and providing information to chaperones or host families who are responsible for the health and safety of program participants at a specific event. Except in the case of emergency, prior to sharing any medical information, it may have with those external to the University, Extension, or 4-H, every effort will be made to get the permission of the program participant or parent or guardian.*

As a parent or guardian, I understand that if a serious illness/injury develops, medical or hospital care will be given. I further understand that in case of serious illness/injury, I will be notified. However, if it is impossible to contact me, I give my permission for emergency treatment, x-ray or surgery, as recommended by an attending physician.

I also understand that any accident insurance in effect (IF PROVIDED) for the event does not cover pre-existing conditions or self-inflicted injuries.

SIGNED:_____ **DATE**:_____

Parent or Guardian