SESSION #_____Dates_____ to _____

Return to:
Mike Rommel
814 Ten Mile Road
Lynden, WA 98264
Due by July 1

CHILD HISTORY AND MEDICAL FORM
TO BE COMPLETED BY PARENT

Name _____ _____ _____ Sex _____
Last First Initial

Grade Completed _____ Age at Camp _____ Birth Date _____

Parent or Guardian _____ Phone _____

Home Address _____
Street & Number City State Zip

Work Address _____ Work Phone _____

Residence Information: ☐ Farm ☐ Town / Rural Nonfarm <10,000 ☐ Town/City 10,000-50,000 ☐ Suburb >50,000 ☐ City >50,000

Racial/Ethnic Information: ☐ White ☐ Black ☐ Am. Indian/Alaskan ☐ Hispanic ☐ Asian ☐ Hawaiian/Pacific Isl.
(Check all that apply)

Immunization History (Must abide by Washington State Immunization requirements)

VACCINES	Date of Basic Immunization	Date of Last Booster
DPT/Tetanus		
Polio		
Measles		
German Measles		
Mumps		

Health History (Check - giving approximate dates) **Allergies** **Diseases**

Frequent Ear Infections_____ Hay Fever _____ Chicken Pox_____

Heart Defect/Disease_____ Ivy poisoning, Etc_____ Measles _____

Convulsions_____ Insect Stings_____ German Measles _____

Diabetes_____ Penicillin_____ Mumps _____

Bleeding/ clotting Disorder_____ Other Drugs_____ Asthma _____

Any Specific Emotional or Physical condition please complete form on back page

Operations or serious injuries (dates): _____

_____

Chronic or recurring illness: _____

_____

Other diseases or details above: _____

_____

Special diet: _____

_____

Current Medications: _____

_____

Is parent sending it?_____ Yes _____ No

Schedule you would like your child to follow (please be specific) _____

(For Females) Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____Special considerations? _____

Do you give permission for the camp nurse to administer acetaminophen (Tylenol) to your son/daughter? _____ Yes _____ No

IMPORTANT: *Please notify the camp if this camper is exposed to any communicable diseases during the three weeks prior to camp attendance.*

Name of dentist/orthodontist _____ Phone _____

Name of family physician _____ Phone _____

Confidential area:

Physical Condition: _____

_____

_____

Emotional Condition: _____

_____

4-H Camp Cornet provides limited insurance coverage up to $3,000 for accidents and up to $1,000 for illness incurred while attending camp. It is the responsibility of every camper's parent or legal guardian to provide for the campers own accident and health coverage beyond the limits of the camp coverage.

IMPORTANT - MUST BE COMPLETED AND SIGNED FOR ATTENDANCE

PARENTS/ GUARDIANS AUTHORIZATION. This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities as noted by me and examining physician.

I hereby give permission to the physician selected by the camp director to order X- rays, routine tests and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injections and/ or anesthesia and/or surgery for my child as named above. This form may be photocopied for use out of camp.

Signature _____ **Date** _____

Send Medical Form to Camp Cornet, 814 Ten Mile Road, Lynden, WA 98264, by July 1.