Office Use only: Date received_____ EMAIL FAX MAIL Completed Signed Health Form ___YES ____NO Immunization Records Received_____(Date)

Circle Week (s) Attending	CB1	CB2	CLEAF	1	2	3	4	5	6	Mount	Alpine 1	Alpine 2

4-H Camp Overlook Health Form - Due June 1st, 2024

Please allow your health care provider ample time to complete the physician section on the back and return it to us.

This form needs to be completed every year. **Health Forms are not carried over from previous years.** Campers cannot attend camp without this form.

~Forms received after June 1st will also need originals at Sunday Registration~

4-H Camp Overlook, 355 West Main Street, Suite 150, Malone, NY 12953 or **fax: 518-483-6214** or **email: CampOverlook@cornell.edu**

Child's Name: _____ **Parent / Guardian Name:_____**

Birth date: _____/_____/_____ **Age: _____** **Sex:** M F **Weight: _____** lbs.

Home phone (_____)_____ **Work phone (_____)_____** **Cell phone (_____)_____**

Home Address: _____ City: _____ State _____ Zip code _____

If not available in an emergency, notify:

1. Name: _____ Phone: (_____)_____ Cell: (_____)_____

   Address: _____

2. Name: _____ Phone: (_____)_____ Cell: (_____)_____

   Address: _____

Name of camper's physician: _____ Phone: (_____)_____

Date of last physical examination: _____/_____/_____

Family Insurance Coverage

Name of Plan: _____ Health Insurance Company: _____

Name of Employer (if group): _____

Name of Policy Holder: _____ Policy Number: _____

Health History (check if appropriate):

	ADD/ADHD		Bed Wetting		Diabetes		Heart Defect / Disease		Sinusitis
	Asthma		Bleeding / Clotting		Frequent Earaches		Hypertension		Sleepwalking
	Athlete's Foot		Convulsions		Frequent Colds / Sore Throat		Menstrual Problems		MRSA

Allergies

	Penicillin		**Food: Please Specify**		**Environmental: Please Specify**		**Other Drug Allergies**:	**Other Allergies**:
	Peanuts		_____		_____		_____	_____
	Insect Stings		_____		_____		_____	_____
	Latex							

Additional Information: To ensure a successful summer for your child as well as other campers, please provide any information about the participant's behavior and physical, emotional, or mental health which the camp should be aware of:_____

_____

For children with developmental disability or special needs; a parent may be contacted prior to arrival to ensure we can accommodate them. If we do not have the resources to meet your child's needs you will be notified and given a full refund.

Does your child require an aide at school? Y or N **Does your child receive any special services at school?** Y or N

Current Condition or Special Needs: Please describe any recent illness, injury, existing medical condition, restriction or special need that your child has.

_____

_____

Special Dietary Needs: _____

Do we have permission to help administer Bug Spray or Sunscreen that you provide for your child? (circle) YES NO

Emergency Authorization

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the adult leader in charge to hospitalize, secure proper anesthesia, or to order injection or surgery for my son or daughter.

Parent Signature: _____ **Date:** _____

Our Health Director will review this health form before your child arrives at camp. To secure a place for your child at 4H Camp Overlook, we must receive your health forms by JUNE 1st. Due to increased competition for enrollment and the absolute necessity to review health forms before the camper arrives at camp, if we do not receive your health form by this date your child will be in jeopardy of losing his/her spot at camp this summer.

Camper's Last Name: _____ **First Name:** _____ **DOB:** _____/_____/_____ **Weight** _____lbs.

Physician's Section – *To be filled out by an authorized provider ONLY*

Medical Information Provided Is Strictly Confidential. Health Forms are due for review by June 1st.

4-H Camp Overlook, 355 West Main Street, Suite 150, Malone, NY 12953, or fax at 518-483-6214, or email CampOverlook@cornell.edu

Up to Date Immunization Record – REQUIRED. Cornell Cooperative Extension camps will no longer be able accept any exemption other than a doctor issued medical exemption for vaccinations to help ensure public health and safety.

□ Check here if immunization record is attached (**required for camp attendance**)

Health Care Recommendations: Please complete with patient's current regimen for both scheduled and prn medications – use 2nd page if needed. Please bring all regularly taken medications (prescription and over the counter) to the camp nurse when registering. Medications must be in original bottles.

Prescription Medications – attach sheet if needed

If a licensed health care provider does not sign this form, the camper will not be given any prescription or over the counter medication.

Drug Name	Reason for Taking	When is it given:	Dosage	How it is given	Date Started
		□ Breakfast □ Lunch □ Dinner □ Bedtime □ Other time:_____			
		□ Breakfast □ Lunch □ Dinner □ Bedtime □ Other time:_____			
		□ Breakfast □ Lunch □ Dinner □ Bedtime □ Other time:			

Mental, Emotional, Social, Physical Health History: Circle Yes or No for each statement. **Has this child:**

Ever been treated for attention deficit disorder (ADD) or attention deficit / hyperactivity disorder (AD/HD)?	Y or N
Ever been treated for emotional or behavioral difficulties or an eating disorder?	Y or N
During the past 12 months, seen a professional to address mental/emotional health concerns?	Y or N
Had a significant life event that continues to affect the camper's life? (Death of a loved one, family change, adoption, survived a disaster etc.)	Y or N

If you answered Yes to any of the statements above please explain in this space.

The camper is undergoing treatment at this time for the following conditions that could affect their camping experience: (describe below) □ None.

Over the Counter Medication provided by camp.

				Health Care Provider, Please circle yes or no
Tylenol	PO - Chewable tabs, elixir or tabs	Per label instructions by age/weight	Q 4 hr prn for pain or fever >_____°F	Yes No
Ibuprofen	PO - Chewable tabs, suspension, or tabs	Per label instructions by age/weight	Q 6 hr prn for pain or fever >_____°F	Yes No
Robitussin	PO - Syrup	Per label instructions by age/weight	Q 4 hr prn for cough	Yes No
Pepto-Bismol	PO - Chewable tabs, or liquid	Per label instructions by age/weight	Q 30 min to 1 hr prn for diarrhea (no > 8doses/24hr)	Yes No
Tums	PO - Chewable tabs	Per label instructions by age/weight	BID-TID prn for stomach upset	Yes No
Dimetapp	PO – Suspension or tabs	Per label instructions by age/weight	Q 6-8 hr prn for nasal congestion/drainage	Yes No
Benadryl	PO - Elixir, chewable tabs, or pills	Per label instructions by age/weight	Q 6 hr prn for allergic reaction (hives, insect bite)	Yes No
Imodium AD	PO – Tabs	Per label instructions by age/weight	1caplet after 1st BM, and ½ caplet after each subsequent loose BM	Yes No
Loratadine	PO – Chewable tabs	Per label instructions by age/weight	1 tablet daily for allergies	Yes No
Zyrtec	PO – Tabs	Per label instructions by age/weight	1 tablet daily	Yes No
Topical ointments & Spray	PO – Ointment or spray	Per label instructions	Prn for cuts, scrapes & burns	Yes No

Health Care Provider Name: _____ Phone: _(_____)_____

Address: _____ License # _____

Health Care Provider Signature: _____ Date: _____/_____/_____