Camp Health Form – Summer 2024

Ashland County Extension 4-H Ambassador Camp

CAMPER, FAMILY, AND EMERGENCY CONTACT INFORMATION						
Youth Name:		**Birth Date:** ___/___/___		**Age on 1st day of Camp (June 14):**	**Pronouns:**	☐Male ☐Female ☐Other
Name of Custodial Parent/Guardian:			**E-mail Address:**			
Phone Numbers:	**Mobile #**		**Work or Home #**			
Home Address:						
	Street		***City***		***State***	***Zip***
2nd Parent/Guardian or Emergency Contact:			**E-mail Address:**			
Phone Numbers:	**Mobile #**		**Work or Home #**			
Home Address:						
	Street		***City***		***State***	***Zip***

CAMPER HEALTH HISTORY						
YES	***NO***	***Health Conditions (check all that apply)***	***YES***	***NO***	***Allergies (check)***	***Please List Specifics***
☐	☐	Asthma	☐	☐	Insect stings	
☐	☐	Diabetes	☐	☐	Foods	
☐	☐	Epilepsy	☐	☐	Medications	
☐	☐	Psychiatric	☐	☐	Other	
☐	☐	Cognitive/Developmental	☐	☐	Do any allergies require an EPIPEN injection?	
☐	☐	Any dizziness, light-headedness or fainting associated with exercise within the past year?	☐	☐	Is insulin required and carried by youth?	
☐	☐	Any unexplained, rapid, or irregular heartbeat within the past year?	☐	☐	Is an inhaler required and carried by youth?	
☐	☐	A physician has sometime denied or restricted participation in sports due to a heart problem.	**Date of Last Tetanus Booster (mm/dd/yy):**			
Insurance Company Name:			**Policy #:**			

See Page 2 for Medication List and Page 3 for Medication Consent Form

Camp Health Form – Summer 2024

Ashland County Extension 4-H Ambassador Camp

MEDICATION(S) THAT CAMPER WILL TAKE DURING CAMP

Medication #1 and Reason for Taking	*Dosage (mg)*	*Times of day given*	*Prescribing Physician & Phone Number*

Describe side effects (mood/behavior changes, upset stomach, diarrhea):

List any special instructions or additional information regarding the medication that would be helpful to the health care staff:

Medication #2 and Reason for Taking	*Dosage (mg)*	*Times of day given*	*Prescribing Physician & Phone Number*

Describe side effects (mood/behavior changes, upset stomach, diarrhea):

List any special instructions or additional information regarding the medication that would be helpful to the health care staff:

Medication #3 and Reason for Taking	*Dosage (mg)*	*Times of day given*	*Prescribing Physician & Phone Number*

Describe side effects (mood/behavior changes, upset stomach, diarrhea):

List any special instructions or additional information regarding the medication that would be helpful to the health care staff:

Programs may have limited over-the-counter medications available. Select medications that can be administered, if available.

Acetaminophen (Tylenol)	**Hydrocortisone (anti-itch) cream**	**Benadryl**	**Ibuprofen**
YES ☐ *NO* ☐	*YES* ☐ *NO* ☐	*YES* ☐ *NO* ☐	*YES* ☐ *NO* ☐

SUPPORT & ACCOMMODATIONS

As Positive Youth Development professionals, the protection and care of youth is paramount. We work to adapt activities for their individual and unique needs. Please share information that increases our awareness so we can provide quality programming.

Please describe any limitations or restrictions this camper might experience while at camp:

With these experiences above in mind, what support or accommodations usually help the camper participate? Please describe:

Please share any other information that would help us best support this camper:

UW–MADISON EXTENSION

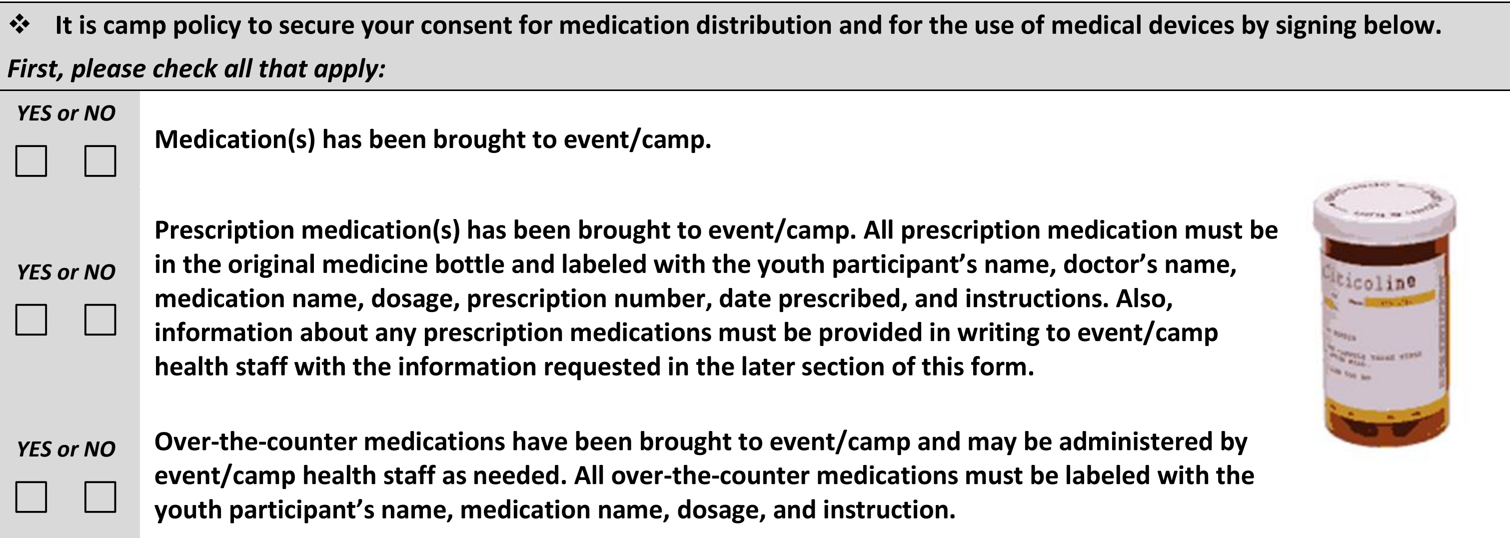
Camp Health Form – Summer 2024

Ashland County Extension 4-H Ambassador Camp

Consent for Medication Administration and Medical Treatment

To the parent/s or guardian/s of this youth:

If this child will be under the age of 18 while participating in a University of Wisconsin – Madison Division of Extension event/camp/program, it is event/camp/program policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device must be administered by designated event/camp/program health staff with the exception that a limited amount of medication for life-threatening conditions may be carried and administered by my son/daughter/ward (i.e. bee sting kit, inhaler, insulin syringe).



❖ **It is camp policy to secure your consent for medication distribution and for the use of medical devices by signing below.**

First, please check all that apply:

YES or NO	
☐ ☐	**Medication(s) has been brought to event/camp.**
☐ ☐	**Prescription medication(s) has been brought to event/camp. All prescription medication must be in the original medicine bottle and labeled with the youth participant's name, doctor's name, medication name, dosage, prescription number, date prescribed, and instructions. Also, information about any prescription medications must be provided in writing to event/camp health staff with the information requested in the later section of this form.**
☐ ☐	**Over-the-counter medications have been brought to event/camp and may be administered by event/camp health staff as needed. All over-the-counter medications must be labeled with the youth participant's name, medication name, dosage, and instruction.**

❖ **If your son, daughter, or ward will be under the age of 18 years old while at the time of camp, it is our policy to secure your consent for all the following items listed below.**

By signing the end of this form,

1. **I am giving my consent in advance for medical treatment at an appropriate medical facility in case of illness or injury.**
2. **I am stating that I am aware of and accept the risk inherent in the program activity.**
3. **I attest that all information on this form is correct and up-to-date, and that I will provide any and all significant material, and important changes to any information in this form to camp staff no later than check-in.**
4. **I agree to hold harmless and indemnify the Board of Regents of the University of Wisconsin System, and the University of Wisconsin-Madison Division of Extension, their officers, agents, and employees from any and all liability, loss, damages, costs, or expenses which are sustained, incurred, or required arising out of the actions of my child or ward in the course of the camp.**

____

Youth Participant Name (Please Print)

____

SIGNATURE OF PARENT OR LEGAL GUARDIAN **DATE**