University of Kentucky
College of Agriculture, Food and Environment
Cooperative Extension Service

Kentucky 4-H Camping Program 2017
Camp Participant Registration – *Camper/Teen (Age 17 or less)*

Last Name:	Legal First Name:	Middle Name:	Preferred Name:
Attended camp before? ❑ Yes - # years: ____ ❑ No	School grade entering:	Birthdate: _____ / _____ / _____	Gender: ❑ M ❑ F
Participant's home address:			Race (check all that apply) ❑ American Indian ❑ Asian ❑ Pacific Islander ❑ White ❑ Black ❑ Hispanic ❑ Non-Hispanic
Participant's Custodial Parent/Guardian #1			
Full Name:	Home Address: ❑ Same as participant		Cell/Home Phone:
Participant's Custodial Parent/Guardian #2			
Full Name:	Home Address: ❑ Same as participant		Cell/Home Phone:
Emergency Contact if above individuals are unavailable			
Full Name:	Relationship to participant:		Cell/Home Phone:
Participant's Family Physician			
Name:	Address:		Phone
Participant's Dentist			
Name:	Address:		Phone

Medication Allergies (list all known)	Reaction & Management:
Food Allergies and Dietary Restrictions (list all known)	Reaction & Management:
Other Allergies (list all known)	Reaction & Management:

Had/does the participant:	**YES**	**NO**		**YES**	**NO**
Had any recent injury, illness, or infectious disease?			Ever had high blood pressure?		
Have a chronic or recurring illness/condition?			Ever been diagnosed with a heart murmur?		
Ever been hospitalized?			Ever had back problems?		
Ever had surgery?			Ever had problems with joints, knees, or ankles?		
Have frequent headaches?			Have an orthodontic appliance brought to camp?		
Ever been knocked unconscious?			Have any skin problems (rash, acne)?		
Wear glasses, contacts, or protective eyewear?			If female, any abnormal menstrual history?		
Ever had frequent ear infections?			Had problems with diarrhea or constipation?		
Ever passed out, dizzy, or chest pain during exercise?			Had mononucleosis in the past 12 months?		
Ever had an eating disorder?			Have diabetes?		
Had problems with sleepwalking?			Have asthma?		
Ever had seizures?			Have a history of bed wetting?		
Ever had emotional difficulties?			Have severe allergies?		
Carry an epi-pen or inhaler?					

Explanation of YES answers:

Immunization Records

Participant is up-to-date on immunizations as outlined by Kentucky law required for enrollment in public school, based upon the grade enrolled.

❑ YES ❑ NO

Date of most recent tetanus shot/booster (Month/Year): _____/_____ ****REQUIRED****

Participant's Insurance Information

Carrier or Plan Name:	Group Number:

Attach a copy (front and back) of the participant's insurance card in the boxes below. Please use tape. **DO NOT STAPLE**.

FRONT

BACK

❑ Participant is not covered by medical insurance.

CAMP USE ONLY:	
Health History reviewed by camp medical personnel on:	

AUTHORIZATIONS/RELEASES

This is a legal document. You must read and understand it before signing it.

Consent to Treat:
The health history reported on page one and two are correct and complete to the best of my knowledge. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer over the counter medication, assist in administering participant's prescription medications as needed, and seek emergency medical treatment including ordering x-rays and routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including trips out of camp.

Parent/Guardian Signature: _____ Date: _____

Media Release:
I grant the Kentucky 4-H Program and the University of Kentucky, and persons acting through them, the right to use, reproduce, assign, and/or distribute photographs, films, videotapes, and sound recordings of my minor child without compensation for use in promotion/advertising, educational publications, electronic publishing, and personal memorabilia. Participant names may be published.

Parent/Guardian Signature: _____ Date: _____

Code of Conduct:
I have read and discussed the Code of Conduct with my participant. We (parent/guardian and participant) understand and agree to comply with the guidelines. Violations may result in the loss of privileges, removal from camp with no refund, assessment of a damage fee I will be responsible for paying, and/or ineligibility to participate in future 4-H events. An incident report will be completed for major violations.

Parent/Guardian Signature: _____ Date: _____

Permission to Participate:
I understand that my child's participation in the Kentucky 4-H Summer Camping Program is based on the challenge by choice philosophy. I recognize that programs are designed to use experiential, engaging teaching techniques, but that my child's participation is purely voluntary, at all times, and my child will choose his or her level of participation in any activity. My initials below grant participant permission to participate in these specialized higher risk activities. No initials will assume the participant may NOT participate.

_____High Ropes Course _____ Low Ropes Course _____ Archery _____ Rifles _____ Trap *(When offered)* _____ Horses *(West KY only)*

Pick-up Release:
It is my responsibility to arrange to pick up my child/children upon return from camp. There will be no exceptions to this policy regardless of relationship to the child. Please inform everyone approved by you on this release that he/she must present a driver's license or photo ID before the child will be released. If a participant's parents are separated or divorced, unless the camp is provided with a copy of a Kentucky court order to the contrary, both biological and adoptive parents have access to the participant. The following individuals have my permission to pick up my child/children.

NAME: _____ RELATIONSHIP_____ Phone/Cell# _____

NAME: _____ RELATIONSHIP: _____ Phone/Cell# _____

NAME: _____ RELATIONSHIP: _____ Phone/Cell# _____

Parent/Guardian Signature: _____Date: _____

Assumption of Risk and Release of Liability:
I acknowledge that there are certain risks, hazards, and dangers, including the risk of physical injury, disability, or death and risk of loss of use or damage to my personal property as a result of allowing participation in the camping program. Risks include but are not limited to recreational games and traditional camp activities, transportation accidents, weather-related hazards and natural disasters, infectious diseases, the possibility of slips and falls, pinches, scrapes, twists, and jolts that could result in scratches, bruises, sprains, lacerations, fractures, concussions, or even more severely debilitating or life-threatening hazards. I understand that injury or loss may result from unknown or unexpected risks and the use of equipment, materials, or facilities recommended by the University of Kentucky; environmental conditions; from the acts or omissions of others; or from the unavailability of immediate and/or adequate emergency medical care. I understand that the University of Kentucky does not guarantee the personal health or safety for participants, nor does it protect against the risk of loss of personal property. In consideration for allowing my child to participate in the camping program, I do hereby release Kentucky 4-H Camp, the University of Kentucky, and its members, trustees, officers, employees, independent contractors, volunteers and extension staff from any and all liability, damages, cost and expenses arising out of or relating to bodily or psychological injury, loss of life, or personal property that may occur as a result of participating in the camping program.

Participant Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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4-H Summer Camp Medication & Prescription Form 2017

Participant's Name: _____ Age: ___ Weight:_____

Camp: _____ County: _____ Cabin Number: _____

For Office Use Only
Date:
_____
Health Care Provider (HCP's Initials)
_____

INSTRUCTIONS: The following **must be completed for each medication brought to camp** that is to be taken by your child during 4-H camp. Please list medications **in the order** in which they are to be taken. **This includes inhalers**. Fill in the name and dosage (as listed on the container) for each medication, along with any special instructions (take with food, etc.). Please place an ✓ in the appropriate Day/Time slot under the parent column for when medicine should be administered. Or check mark As Needed next to Dosage if appropriate. **PLEASE SEND ONLY THE NUMBER OF PILLS YOUR CHILD WILL NEED FOR THE CAMP SESSION IN THE ORIGINAL CONTAINER(S).** (HCP will initial as medication is given.)

PLEASE LIST any medications that should be kept with the participant all times (i.e. EpiPen, inhaler):

1. Prescription Name: _____ Dosage: _____ As Needed: (✓)_____
Special Instructions:

	Breakfast		Noon		Dinner		Bedtime		Other	
	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

2. Prescription Name: _____ Dosage: _____ As Needed: (✓)_____
Special Instructions:

	Breakfast		Noon		Dinner		Bedtime		Other	
	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials	Parent (✓)	HCP' Initials
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

Parent Declaration: I, _____, as the parent or legal guardian of_____, in the event that my directions differ from those on the original container, understand that I must obtain a note from the prescribing physician confirming the directions that should be followed in administering medications to my child. Furthermore, I understand that if there are any questions or concerns, I may be contacted at (H) _____ (Cell) _____

Participant Name: _____

3. Prescription Name: _____ Dosage: _____ As Needed: (✓)_____

Special Instructions:

	Breakfast		Noon		Dinner		Bedtime		Other	
	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

4. Prescription Name: _____ Dosage: _____ As Needed: (✓)_____

Special Instructions:

	Breakfast		Noon		Dinner		Bedtime		Other	
	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

5. Prescription Name: _____ Dosage: _____ As Needed: (✓)_____

Special Instructions:

	Breakfast		Noon		Dinner		Bedtime		Other	
	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials	Parent (✓)	HCP's Initials
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

ALL MEDICATION MUST BE IN ORIGINAL CONTAINERS