

# 2014 Alpine 4-H Horse Camp Participant Health Form

## Medical History and Consent for Treatment

The following information is being voluntarily supplied by the parent/guardian or self for the sole purpose to supply any emergency responder with medical information to insure the best care in case of an emergency situation. This information will be kept confidential and will only be used in case of a medical emergency.

Name				Age	Birthdate
Address	City	County	State	Zip	Grade
Parent or Legal Guardian		Home Phone	Work Phone	Cell Phone	
In case of emergency and parents cannot be reached, contact:		Relationship	Home Phone	Other Phone	
Family Physician			City	Phone	
Are vaccines/immunizations current? <input type="checkbox"/> Yes <input type="checkbox"/> No			Date of last vaccination		
Have you received a tetanus vaccination within the last 10 years? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure					

### Health History

Do you have a history of the following medical conditions? Place a check in the box.

Condition		Comments	Date of Condition
Allergies- Food			
Allergies- Insect			
Allergies- Medications			
Asthma			
Bleeding/ Clotting Disorders			
Chicken Pox			
Diabetes			
Disabilities			
Eating Problems			
Emotional Problems			
Epilepsy			
Fainting			
Measles			
Mumps			
Other			
Stomach Aches			

Urinary Problems			
Physical Limitations or current conditions that we should be aware of, i.e. stitches, sprains, casts, etc:			

### Medications

Please list all medications that the camper is taking including Tylenol, aspirin, inhalers. Please check. Add additional sheet if necessary.						
Medication	Dosage	Frequency	OTC	Preparation	Self-Medication	To be dispensed by

### Medical Insurance Information

Medical Insurance Co. \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Insured \_\_\_\_\_ Social Security # of insured \_\_\_\_\_

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**I verify that the medical information listed above is complete and accurate. I also understand that reasonable measures will be taken to safeguard the health and safety of all participants and that I or my contact will be notified as soon as possible in case of an emergency. In the event I cannot be reached, I hereby authorize the calling of a physician at my expense to provide whatever emergency medical or surgical treatment as necessary. I also authorize camp personnel to release the above medical insurance information to appropriate medical facilities.**

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Date

3/2014