

SESSION # _____ Dates _____ to _____

Return to:
Glenn DePeralta
3111 Newmarket St. #411
Bellingham, WA 98226
Due by July 1

COUNSELOR HISTORY AND MEDICAL FORM

TO BE COMPLETED BY PARENT

Name _____ Sex _____
Last First Initial

Grade Completed at camp _____ 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: Caucasian African American Native American/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: Vegetarian No Red Meat Other (please explain) _____

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** _____

SIGN

I hereby grant permission to Camp Cornet and WSU Extension the right to use, reproduce, and/or distribute photographs, films, video-tapes and sound recording of my child, without compensation or approval rights, for use in materials created for the propose of promoting the activities of Camp Cornet and WSU Extension. _____ (signature)

SIGN

Please return to: Glenn DePeralta, 3111 Newmarket St. #411, Bellingham, WA 98226, by July 1.