Dear Parents/Guardians,

Please complete this entire medical form. We ask that each camper have had a physical exam by a healthcare professional sometime within the past 24 months. Take this form to your healthcare professional to complete. If your child has had a physical for school or athletics, you may photocopy it and attach it to our form, but please, answer all questions on our form as well.

We May Need More Detailed Information:

Name of your child: _____ _____ _____

First Middle Last

1) If you will be leaving medications for us to administer, please use the space below to describe symptoms or behaviors that are connected to the condition being treated. Please let us know how you respond to these symptoms and behaviors. We would like to offer your child consistent, familiar care.

2) Does your child have a history of anxiety, bedwetting, homesickness, or other non-medical concerns? Please explain and share you suggestions with us.

3) Optional – We are continuously seeking scholarship funds to assist families with tuition costs. This information will help us with our grant writing process. Do you currently receive free or reduced lunch at your school?

Yes _____(please circle free or reduced and complete and sign the attached School Meal Application including your Food Stamp or TANF Case Number)

No _____

4) Optional - It is important that we ensure equal opportunity to all who might benefit from our programs. As a way to document those we are reaching, we are seeking the following information on an optional and anonymous basis.

1} ___ American Indian and Alaska Native

2} ___ Asian

3} ___ Black or African American

4} ___ Hispanic or Latino

5} ___ Native Hawaiian and other Pacific Islander

6} ___ White (Caucasian)

The information that you share with us is confidential and will be stored with your child's medical form. Thank you for your help!

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Bryant Pond 4-H Health Policy

Outbreaks such as H1N1, Norovirus, lice infestation, etc. are unlikely, but can occur at summer camps. While Bryant Pond 4-H was able to escape the H1N1 outbreak last year, we were careful to pay close attention to any symptoms that may be exhibited by campers when arriving at camp. We have put in place a couple of medical prevention policies to ensure the health and wellness of all campers and staff.

Our camp professionals regularly evaluate and update our Bryant Pond health-care practices and procedures.

1. The Bryant Pond 4-H Camp reserves the right to check campers upon arrival for and sign of fever, illness, and head lice performed by medical professionals in a respectful and confidential manner.
2. Bryant Pond recognizes that parents may choose not to have their child participate in this basic check-in procedure, but as a result the child may not be admitted to camp and a refund will be mailed.
3. Bryant Pond does send children home in accordance with the University of Maine policy, ACA medical and DHHS policy if they have signs of serious contagious illness.

Travel Release

Occasionally, our programs may include a field trip to local mines and other various locations. I give my son/daughter _____permission to travel with licensed Bryant Pond Staff on field trips during his/her stay at camp. All our drivers are screened prior to employment by the University of Maine and have been approved to transport campers.

_____ _____

Parent or Legal Guardian Date

University of Maine 4-H Camp & Learning Center
PO Box 188
Bryant Pond, ME 04219
(207) 665-2068

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Camper Name_____

MEDICATION ADMINISTRATION LIST

Please circle all of the following medications that are all right for your child to be given if it is found necessary by the medical staff:

- **Ibuprofen**
- **Pepto Bismol**
- **Antihistamine/Benadryl**
- **Tums**
- **Sudafed**
- **Cold & Cough Medication**
- **Children's Motrin**
- **Junior Tylenol**
- **Caladryl**
- **Imodium**

Parent/Legal Guardian _____

Phone Number_____

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Bryant Pond 4-H Camp and Learning Center Participants, please complete all forms and return to:

Bryant Pond 4-H Camp and Learning Center
P.O. Box 188
Bryant Pond, ME 04219

Questions?
Call 207-665-2068, or email bp@umext.maine.edu

Bryant Pond 4H Camp and Learning Center

Confidential Health History and Examination Form for Summer Camp and Expeditions

Name_____
Last First MI
Home address_____
Street City State Zip code
Birth Date_____ Gender Male ☐ Female ☐

Custodial parent/guardian (if under 18)_____
Phone_____
Home address (if different from above)_____
Business address _____ Phone_____
If not available in an emergency notify:
Name_____
Relationship_____ Phone_____
Address_____
Street City State Zip code

Insurance Information
Is the participant covered by family medical/hospital insurance? Yes No
If so, indicate carrier and plan name_____ Group#_____

Photocopy of front and back of health insurance card must be attached to this form
Important - These boxes must be complete for attendance*

Parents/Guardian or Adult Authorization: This health history is correct and complete as far as I know. The person herein described has permission to engage in all program activities except as noted. I herby give permission to Bryant Pond to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to Bryant Pond to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission for the physician selected by Bryant Pond to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of Bryant Pond base camp.

Signature of parent/guardian or adult participant:_____
Printed Name_____ Date_____
I also understand and agree to abide by any restrictions placed on my participation in program activities by medical personnel.
Signature of minor or adult participant_____ Date_____

**If for religious reasons you cannot sign this, contact the Bryant Pond for a legal waiver which must be signed for attendance.*

Health History
The following information must be filled in by the parent/guardian, or adult. The intent of this information is to provide Bryant Pond health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to health personnel upon participant's arrival Bryant Pond base camp. Provide complete information so that Bryant Pond can be aware of your needs.

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Allergies List all known — **Describe reaction and management of the reaction**

Medication allergies (list)

_____ _____
_____ _____
_____ _____
_____ _____

Food allergies (list)

_____ _____
_____ _____
_____ _____
_____ _____

Other allergies (list) - include insect stings, hey fever, asthma, animal dander, etc.

_____ _____
_____ _____
_____ _____
_____ _____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or Non-prescription drugs) taken routinely. Bring enough medication to last the entire time at the program. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration.

☐ **This person takes NO medications on a routine basis.**

☐ **This person takes medications as follows:**

Med #1_____Dosage_____ Specific times taken each day_____
Reason for taking_____

Med #2_____Dosage_____ Specific times taken each day_____
Reason for taking_____

Med #3_____Dosage_____ Specific times taken each day_____
Reason for taking_____
Attach additional pages for more medications

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

Does not eat red meat ☐ Does not eat pork ☐ Does not eat eggs ☐

Does not eat poultry. ☐ Does not eat seafood ☐ Does not eat dairy products ☐

Other
(describe)_____
_____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)?

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General Questions (Explain "yes" answers below)	**Yes**	**No**		**Yes**	**No**
1. Had any recent injury, illness or infectious disease?	☐	☐	16. Ever had back problems?	☐	☐
2. Have a chronic or reoccurring illness/condition?	☐	☐	17. Ever had problems with joints (knees,ankles)?	☐	☐
3. Ever been hospitalized?	☐	☐	18. Have an orthodontic appliance being brought to camp?	☐	☐
4.Ever had surgery?	☐	☐	19. Have any skin problems (itching, rash, acne)?	☐	☐
5.Have frequent headaches?	☐	☐	20. Have diabetes?	☐	☐
6. Ever had a head injury?	☐	☐	21. Have asthma?	☐	☐
7. Ever been knocked unconscious?	☐	☐	22. Had mononucleosis in the past 12 months?	☐	☐
8.Wear glasses, contacts or protective eyewear?	☐	☐	23. Had problems with diarrhea/constipation?	☐	☐
9. Ever had frequent ear infections?	☐	☐	24. Have problems with sleepwalking?	☐	☐
10. Ever passed out during or after exercise?	☐	☐	25. If female, have an abnormal menstrual history?	☐	☐
11.Ever been dizzy during or after exercise?	☐	☐	26. Ever had an eating disorder?	☐	☐
12. Ever had seizures?	☐	☐	27. Ever had emotional difficulties for which professional help was sought?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐	28 . Ever had a history of bed wetting	☐	☐
14.Ever had high blood pressure?	☐	☐			
15. Ever been diagnosed with a heart murmur?	☐	☐			

Please explain any "yes" answers, noting the number of the questions.

Which of the following has the participant had? Please give all dates of immunization

Vaccine	**Dates**	**Vaccine**	**Dates**
Measles		DPT	
Chicken pox		TD (tetanus/diphtheria)	
German measles		Tetanus	
Mumps		Polio	
Hepatitis A		MMR	
Hepatitis B		or Measles	
Hepatitis C		or Mumps	
		or Rubella	
Mantoux Test		Haemophilus Influenza B	
Date of last test?		Varicella (chicken pox)	
Results: Positive ☐	Negative ☐		

Any person with a disability who needs accommodations for this program should contact Ryder Scott to discuss their needs at least 21 days in advance. Please use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which Bryant Pond staff should be aware and/or request for special accommodations.

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Name of family physician_____ Phone_____

Address_____ City_____ State _____ Zip Code_____

Name of family dentist/orthodontist_____ Phone_____

Address_____ City_____ State _____ Zip Code_____

◊ Health Care Recommendations by medical personnel- This section is to be filled out by a licensed medical professional only ◊

I examined the individual on _____
BP_____ Weight_____ Height_____

In my opinion, the above applicant ____is ____ is not able to participate in a winter expedition course.

The applicant is under the care of a physician for the following conditions:
_____
_____

Recommendations and restrictions while participating in the program:
Treatment to be continued at Bryant Pond
_____
_____

Medications to be administered at camp (name, dosage, frequency)
_____
_____

Any medically-prescribed meal plan or dietary restrictions
_____
_____

Known allergies
_____
_____

Description of any limitations or restrictions on program activities
_____
_____

Additional information for health care staff at the camp

Signature of Licensed Medical Professional_____
Printed_____ Title_____
Address_____
Phone_____ Date_____

For Program use only

Screening Record
Date screened_____ Time _____am/pm
Meds received_____
_____
Updates/additions to health history noted _____Yes _____No _____None required_____
Current health needs identified_____
_____
Observational notes_____
_____Screened By_____