Ohio FFA Camp Muskingum

Students Health and Registration Form

Please thoroughly read and complete **BOTH** sides of this form

General Information

Name _____

Age _____ Sex _____ Weight _____ Height _____ Date of Birth _____/_____/_____

Address _____
(Street) (City) (State) (Zip)

_____ _____ _____

Mother's Name or Legal Guardian Home # Work #

_____ _____ _____

Father's Name or Legal Guardian Home # Work #

Family Doctor _____ Doctor's # _____

If parents are not available in case of an emergency, notify: _____ Phone Number _____

Insurance Information

Is this person covered by family health insurance plan? Yes___ No___

If covered, what is the insurance company? _____

Name of person who is the prime insured holder: _____

Please write the insurance I.D. number (It is on your Insurance Card) _____

I give permission for (**student's** name) _____ to attend Friends Youth United at FFA Camp Muskingum and to be subject to the authority of the program director. I give permission for the above to participate in any planned activities under the supervision of the director. I also understand that the director may dismiss my child from the encampment if, in their opinion, his/her conduct or influence is not in the best interest of the entire group. I will not hold FRIENDS YOUTH UNITED responsible or liable for accidents which may occur to the camper while on the camp premises, or for loss of personal articles brought to FFA Camp Muskingum. I also give permission for use of any photo of the above named to be used for program public relations.

I understand that my child will have the opportunity to participate in a large array of activities that include the following: Canoeing, Kayaking, Row Boats, Athletic Sporting Events including Water Sports, High Ropes, Low Ropes, Climbing Wall and Lasertag..

I hereby give permission for emergency treatment of my child in case of accident or illness, and for normal treatment during the program. I realize that the FRIENDS YOUTH UNITED director and or nurse will make every effort to contact, first the *legal guardians,* followed by the person to notify in case of emergency. If neither one can be reached, I hereby give permission to the medical personnel selected by the program director and/or assigned staff member to order routine tests, X-rays, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation. I also give permission to the physician selected by the program director and/or assigned member to secure and administer treatment, including hospitalization, for the person named above.

Non-Prescription Medication: Should my child become ill, get a headache, catch a cold, or have other minor medical or dental problems, I give permission for the administration of non-prescription medication in accordance with the camp's medical treatment procedures? **(PLEASE MARK ONE)** Yes____ No____

If needed, Tylenol will be administered, unless otherwise specified: Other (specify) _____

I understand that by signing below I have read and understand the above statements.

_____ _____ _____

Signature Relationship Date

Health Information
This health form must be filled out completely and thoroughly

Dear Parents:
If your child must take any medication, carefully read the medication instructions below. Medication WILL NOT be administered unless all of the instructions are properly followed. It is necessary that the school and camp authorities know your child's physical and mental condition. If you have any doubt that your child is in good health, have a physician examine your child and forward the report to the camp.

1. Medication
a. If your child must take any medication, send medicine in the ORIGINAL CONTAINER.
b. PRESCRIPTION MEDICATIONS must be accompanied by a pharmacy label containing the RX number, the name of the medication, and dosage, directions for administration, and the child's name.
c. NON-PRESCRIPTION MEDICATIONS must be in their original containers, clearly labeled with the child's name, name of the medication, and directions for its use.
d. Medicine lying loose in sandwich bags or other containers will not be administered.
e. Your child will not be allowed to keep any medications in the dormitory.

Please complete the following areas that pertain to the student.

Please check the appropriate Box: ☐ This Person takes NO medication on a routine basis.

☐ This person takes medication as follows:

Medication	Reason (optional)	Dosage	√ if prescribed by Doctor	Administering Directions	√ if Taken with Food	Due to program scheduling, medications are administered during meal times. Please circle approximate times meds are taken.
						7:30am 12:00pm 5:30pm 10:30pm Other____ am/pm
						7:30am 12:00pm 5:30pm 10:30pm Other____ am/pm
						7:30am 12:00pm 5:30pm 10:30pm Other____ am/pm

Please Look Over and Follow the Medication Instructions Above
I hereby give permission to the program director, assigned staff member, and/or school personnel to help self administer medication to the student stated on this form.

_____ _____ _____
Signature Relationship Date

2. Allergies (food, insect bites, drugs, others): _____
3. Has your child been exposed to any communicable disease within the past 10 days? If yes, what disease _____
4. Are there any physical activities in which your child should not participate? _____
_____
5. Has your child ever had a problem with homesickness? If YES, please explain briefly? _____
_____
6. Date of last tetanus shot, if known: _____
7. Is your child up to date on all immunizations required for school? _____
8. Any other information we need to know about your child (special health concerns, special diet, recent hospitalizations, fractured bones, etc.): _____
_____

Please feel free to attach an additional form if your child takes additional medication or there is anything else you think we need to know.