

**Ohio Leadership Camp at Camp Muskingum**  
Students Health and Registration Form  
Please thoroughly read and complete **BOTH** sides of this form

Chapter \_\_\_\_\_  
Bed # \_\_\_\_\_

**General Information**

Name \_\_\_\_\_ Home Chapter \_\_\_\_\_

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 \_\_\_\_\_

What are the Last Four Digits of the Student's Social Security Number \_\_\_\_\_

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 Ohio Leadership Camp 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 Ohio Leadership Camp at Camp Muskingum responsible or liable for accidents which may occur to the camper while on the camp premises, or for loss of personal articles brought to Ohio Leadership Camp at 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's participation in programs offered by Ohio Leadership Camp at Camp Muskingum including the adventure activities and living history reenactments are based on a "Challenge by Choice" philosophy. I recognize that the program is designed to use experiential hands on teaching techniques, and that my child's participation is purely voluntary. I also understand that my child will have the opportunity to participate in a large array of activities that include the following: Rifle, Shotgun, Archery, Motor Boats, Canoeing, Kayaking, Row Boats, Overnight Camp-out, Athletic Sporting Events including Water Sports, High Ropes, Low Ropes, Climbing Wall and Paintball.

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 Ohio Leadership Camp at Camp Muskingum 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:	<input type="checkbox"/>	This Person takes NO medication on a routine basis.
	<input type="checkbox"/>	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 <input type="text"/> am/pm
						7:30am 12:00pm 5:30pm 10:30pm Other <input type="text"/> am/pm
						7:30am 12:00pm 5:30pm 10:30pm Other <input type="text"/> 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. 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.**