2019

2019 4-H Special Clovers Registration Packet March 23 & 24, 2019

DEADLINE: Registration is due in the State Office February 1st

Camp is limited to the 1st 15 paid 4-H members

Date: _____/_____/_____

Camper Name: _____ Nickname: _____
First Middle Last

[ ] Male [ ] Female Date of Birth: _____/_____/_____ Age: _____
month day year

County Due Date: _____

Please circle shirt size and check √ Youth or Adult: Shirt Size S M L XL XXL 3XL other: _____ [ ] Youth or [ ] Adult

Name & phone # of camper's parent/guardian: _____ Cell (___)___-_____

County: _____ 4-H Member is active in 4H Online: _____

Camper Home Phone: (___)___-_____ Camper Address: _____
City State Zip Code

Guardian's Relationship to Camper: _____

E-mail: _____

CONTACT INFORMATION: (primary contact will serve as initial contact for emergency and non-emergency situations)

- Primary Contact: _____ Relationship to Camper: _____
First Last

1st Phone: (_____)_____-_____ 2nd Phone: (_____)_____-_____
Please circle to indicate: (home, mobile, work) **Please circle to indicate**: (home, mobile, work)

- Secondary Contact: _____ Relationship to Camper: _____
First Last

1st Phone: (_____)_____-_____ 2nd Phone: (_____)_____-_____
Please circle to indicate: (home, mobile, work) **Please circle to indicate:** (home, mobile, work)

- Third Contact: _____ Relationship to Camper: _____
First Last

1st Phone: (_____)_____-_____ 2nd Phone: (_____)_____-_____
Please circle to indicate: (home, mobile, work) **Please circle to indicate:** (home, mobile, work)

CAMPER INFORMATION:

Youth who require assistance with bathing, restroom, or lifting must provide a caregiver to provide those duties during the duration of the camp.

Primary Disability: _____ Secondary Disability: _____

Caregiver Name: ***Only if caregiver is attending camp with camper*** _____

Camper requires one-on-one assistance: [ ] Yes [ ] No If yes, please explain: _____

**The people listed below may drop off/pick up camper.

(1) _____ (2) _____ (3) _____

2019

Please return completed Paperwork to: Oklahoma State 4-H, 205 YD, Attn: Cathy Allen, Stillwater, Ok 74078

Allergies: [ ] No known allergies. Camper is allergic to: [ ] Food [ ] Medicine [ ] The environment (insect stings, hay fever, etc.) [ ] Other
(Please describe below what the camper is allergic to and the reaction seen.)

Restrictions: [ ] I feel the camper can participate in all camp activities without restrictions.
[ ] I feel the camper can participate in all camp activities with the following restrictions or adaptations. ***(Please describe below.)***

Seizure History:
This camper has an active seizure condition [ ] Yes [ ] No

Date of last seizure: _____

If yes:, type: _____

Frequency: _____

Length of seizure: _____

Triggers: _____

Please describe:

Health History: ***(Please check and explain any past health issues below)***

[ ] Heart defect/disease
[ ] Mumps
[ ] Poison Ivy
[ ] Poison Oak
[ ] Diabetes
[ ] Chicken Pox
[ ] Mononucleosis
[ ] High Blood Pressure
[ ] Hay Fever
[ ] Ear Infections
[ ] Measles
[ ] Asthma
[ ] Swimmer's Ear
[ ] Other:_____

Please describe:

MEDICAL INFORMATION - Oklahoma 4-H requests the information below so that in case of emergency, we have accurate information to provide and/or seek appropriate treatment for Participant. You are accountable for providing an accurate medical history. If Participant has any medical issue that is not requested below, but which you think is important, please include that information. If you are uncertain about any pre-existing medical conditions, it is your responsibility to consult with your own physician prior to participating in this Program. As a participant, parent, or guardian it is your responsibility to disclose relevant information that may result in harm to Participant and/or others during this Program. I agree to notify the 4-H program of any changes in the mental, physical or medical condition of the Participant prior to any scheduled Program.

In cases where medical attention is necessary, parents will be contacted for approval when possible; however, in the event of an emergency the 4-H staff will seek medical care for any child in their care. A Nurse will be on duty during the duartion of the camp.

Physician's Name:	Phone Number:
Date of most recent tetanus toxoid immunization:	

 Please return completed Paperwork to: Oklahoma State 4-H, 205 YD, Attn: Cathy Allen, Stillwater, Ok 74078

Do you have health/accident insurance? (circle one): ☐ YES ☐ NO

IF YES, ATTACH A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD TO THIS FORM

Insurance Company Name:

Address:

Policy/Group#	ID#

AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION

Generally 4-H staff will only have minor first aid supplies at overnight events and will avoid dispensing medications; however, at times a child may become ill while on an extended event and unless we have parental authorization, we cannot administer ANY medications.

Below is a list of common OTC medication. By checking, I authorize that the following medications may be given to Participant if the need arises. I shall indemnify and hold harmless the Program Staff, Oklahoma State University, its Board of Regents, Administration, Faculty, Staff, Student Leaders, and all other officers, directors, employees and agents against any claims that may arise relating to my child being administered the below indicated over- the-counter medications.

Category 1 - *May be administered without phone approval*

- ◊ Sunscreen
- ◊ Bug repellent
- ◊ Ointments for minor wound care or first aid as directed. (Antiseptic, anti-itch, anti-sting, antibiotic, sunburn)
- ◊ Tylenol/Acetaminophen as directed.
- ◊ Ibuprofen as directed.
- ◊ Throat lozenges and or spray as directed for sore throat.
- ◊ Hydrocortisone ointment as directed for mild skin irritations, poison ivy, and insect bites.
- ◊ Medicated powder for skin irritation as directed.
- ◊ Calamine lotion for bug bites and poison ivy.
- ◊ Medicated lip ointment for dry, chapped lips, lip blisters or canker sores as directed.
- ◊ Other (list any other approved over-the counter drugs)

Category 2 - *May be administered without phone approval, when possible will be discussed with parents first.*

- ◊ Kaopectate or Imodium for diarrhea as directed.
- ◊ Milk of Magnesia, Pepto-Bismol or Mylanta for upset stomach or nausea as directed.
- ◊ Rolaids or Tums for acid reflux, heartburn or indigestion as directed.
- ◊ Benadryl for swelling, hives, allergic reaction, as directed.
- ◊ Actifed or Sudafed as directed for nasal congestion or allergy relief per instructions.
- ◊ Visine or other eye drops for minor eye irritation.
- ◊ Swimmer's ear drops as directed.
- ◊ Robitussin or other cough syrup as directed.
- ◊ Other (list any other approved over-the counter drugs)

 Please return completed Paperwork to: Oklahoma State 4-H, 205 YD, Attn: Cathy Allen, Stillwater, Ok 74078

Please fill this section out accurately and completely. **If changes to medical condition and/or medication occur and are different from what you listed on this form, please let us know upon arrival at camp.** List all medications and treatments prescribed to the camper including: lotions, creams, inhalers, liquids, allergy medications, cold medications, injections, and temporarily prescribed medication, including all over the counter medications, vitamin/mineral supplements, herbs, homeopathic remedies, other treatments, etc. that camper is currently taking. Any administration advice is greatly appreciated.

Medications will be dispensed at **B**-Breakfast, **L**-Lunch, **D**-Dinner, **HS**-Hour of Sleep
unless otherwise specified below under special instructions. Make additional copies or attach additional paper as needed.
Each item listed must include accurate name, strength, dosage, times, and instructions.

☐ **N/A - Camper takes no medication, supplements, OTC remedies, etc.**

Name of Medication Strength of Each Individual Pill and Route	**Dosage** **At Each Time**	**Times** use B, L, D, HS if possible	**Comments or Special Instructions** crushed, with food or how medication is given at home side effects, history of refusal or hiding medication
Ibuprofen—200 mg, oral ***Example***	200 mg	B	Take with food and plenty of water.
	200 mg	L	Take with food and plenty of water.
	100 mg	@4:30 PM	Split 200 mg tablet in half, crush, mix with pudding.
	100 mg	HS	Split 200 mg tablet in half & take with water, might refuse.

Please return completed Paperwork to: Oklahoma State 4-H, 205 YD, Attn: Cathy Allen, Stillwater, Ok 74078

MOBILITY/ POSITIONING	***** Please circle which best applies *****			**Comments:**
- Uses wheelchair	No	Manual	Electric	
- Bears weight	Yes	No	With assistance	
- Transfers	Alone	With assistance		
- Please list any additional adaptive equipment for mobility (walker, cane, braces, etc.).				
Additional mobility comments:				

COMMUNICATION	**Please circle Yes or No**		**Comments:**
-Verbal	Yes	No	
- Uses sign language	Yes	No	
- Uses communication device ***please bring device***	Yes	No	
- Uses eye gazes	Yes	No	
- Additional communication information ***List special words or phrases used at home***			

BEHAVIOR CONCERNS *** answers will NOT exclude individual, but will ensure the best possible care ***	**Please circle Yes or No**		**Comments:**
- Shows aggression toward others	Yes	No	
- Shows aggression toward self	Yes	No	
- Please describe any negative behaviors			
- Please describe helpful behavior strategies or interventions			
Additional behavior information:			

DRESSING (Please check box)	**Independent**	**Needs Verbal Prompts**	**Needs Physical Assistance**	**Comments:**
- Unpacks/Packs self				
- Dresses self				

Please return completed Paperwork to: Oklahoma State 4-H, 205 YD, Attn: Cathy Allen, Stillwater, Ok 74078

Eating - Please check box	**Independent**	**Needs Verbal Prompts**	**Needs Physical Assistance**	**Comments:**
- Eats				
- Drinks				
- Uses adaptive equipment for eating/drinking?	Describe:			
- Has food allergies/sensitivities/restrictions?	Describe:			

Hygiene - Please check box	**Independent**	**Needs Verbal Prompts**	**Needs Physical Assistance**	**Comments:**
- Takes a shower				
- Shampoos hair				
- Dries off				
- Brushes teeth				
- If avoids showers, shampooing, brushing teeth, please provide techniques on how to persuade.				
- Uses adaptive equipment for showering?	Describe:			

TOILETING - Please check box	**Independent**	**Needs Verbal Prompts**	**Needs Physical Assistance**	**Comments:**
- Uses toilet appropriately				
- Asks to use the toilet				
- Can wipe				
- Uses catheter				
- Wears Depends ***please provide***	When are they worn?			
- Has bathroom schedule - Circle **Yes or No**	Describe:			
- List and describe any adaptive equipment for toileting that is required:				

NIGHTTIME ROUTINE	**Please circle Yes or No**		**Comments:**
- Sleeps through the night	Yes	No	
- Has special sleep habits *** example: music, sleeps with stuffed animal, sleep walks ***	Yes	No	
- Has history of wetting or soiling bed *** Please send extra bedding ***	Yes	No	
Additional Information:			

Help camp staff get to know your camper and list suggestions below in the box provided.
***** Hobbies, Interests, Preferred camp activities *****

Hobbies:
Interests:
Preferred camp activities:
Other information camp should know:

Please return completed Paperwork to: Oklahoma State 4-H, 205 YD, Attn: Cathy Allen, Stillwater, Ok 74078