

**THE OHIO FORESTRY ASSOCIATION, INC.**  
**FORESTRY CAMP**  
1100-H Brandywine Blvd. • Zanesville, OH 43701  
Phone: 888-388-7337 • Fax: 740-452-2552  
E-mail: Info@OhioForest.org • www.OhioForest.org

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_@\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex  M  F

Parents/Legal Guardian Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name of two alternates (relatives or friends) who may be contacted in case parent or legal guardian cannot be reached during an emergency.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Date last seen by a physician: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason: \_\_\_\_\_

Give name and identification number of hospital/medical insurance

Policy #: \_\_\_\_\_ Policyholder: \_\_\_\_\_

If participant has been under the care of a physician within the past 12 months or if there is any question about activity restriction, attach a statement from a physician indicating restrictions and noting any pertinent recommendations.

**General Health and Medical History**

1. Handicap: Do you have any limiting disabilities or conditions (temporary or permanent) that could limit your participation? If yes, please explain: \_\_\_\_\_

2. Any operations, serious injuries or chronic illness? If yes, please specify: \_\_\_\_\_

3. Have you had any of the communicable diseases listed below?  
 Measles  Chicken Pox  Mumps  German Measles (Rubella)

4. List the year of last immunization or booster for the following:  
Tetanus Toxoid \_\_\_\_\_ German Measles \_\_\_\_\_ Diptheria \_\_\_\_\_ Polio \_\_\_\_\_  
Other \_\_\_\_\_

5. Name any know allergies: (include foods, drugs, plants, animals, insects and other) \_\_\_\_\_

Explain reaction and indicate medication/treatment used: \_\_\_\_\_

6. Please indicate any special dietary needs: \_\_\_\_\_

7. Are you prone to any of the following conditions:  Fainting  Convulsions  Stomach upsets  
 Frequent Headaches  High blood pressure  Restlessness or sleepwalking  
 Asthma or respiratory problems  Heart problems  Ear Infections  
 Hay Fever  Rheumatic fever  Penicillin reaction  
 Insect stings  Diabetes  Ivy poisoning  
 Other drug reactions  Other (please specify) \_\_\_\_\_

If you have checked any of the items above, please give details: \_\_\_\_\_

Continued on Reverse

It is a state law that all medication must be in the original container when bringing to camp. All medication must be turned in to nurse. (except in special circumstances with permission by nurse)

8. List medication(s) and use, including insulin. (Must be in original container with prescription and/or store label!)

Medication \_\_\_\_\_ Used for \_\_\_\_\_

When taken \_\_\_\_\_ Dosage \_\_\_\_\_

Medication \_\_\_\_\_ Used for \_\_\_\_\_

When taken \_\_\_\_\_ Dosage \_\_\_\_\_

Medication \_\_\_\_\_ Used for \_\_\_\_\_

When taken \_\_\_\_\_ Dosage \_\_\_\_\_

Do you need any help with medication?  Yes  No Is re Fridgeration needed?  Yes  No

Please explain help needed: \_\_\_\_\_

9. Any known physical, mental, social difficulties or other special information which may affect participation and/or for which special consideration should be given?  Yes  No

If yes, please explain: \_\_\_\_\_

10. Any prior activity restrictions?  Yes  No

If yes, please explain: \_\_\_\_\_

Please check the items that camp personnel have permission to administer to your child:

Ice Pack for fever  Tylenol for minor pain  Splinters removed

Ivy lotion  Topical antiseptic  Band-aids

Cleansing of minor abrasions with soap and water

Other, please specify: \_\_\_\_\_

With my parents, I have completed the above information and will assume responsibility for restricting any activities agreed upon and listed above. I will exercise good judgment in regard to my own health, safety and well-being while participating in this program.

Signature (youth) \_\_\_\_\_ Date \_\_\_\_\_

We hereby make application to enroll our son/daughter in the Ohio Forestry Camp expecting that all normal precautions will be taken to ensure his/her health, safety and well being. We understand that the camp fee does not include accident insurance and that no liability is assumed by the Ohio Forestry Association, Inc. or Offinger Management Co.

The above health history is correct so far as we know, and the person herein described has permission to engage in all Forestry Camp activities except as noted by ourselves and the examining physician. In the event we cannot be reached in an emergency, we hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery in a life-saving situation for our child while at the Ohio Forestry Camp.

Signature (mother) \_\_\_\_\_ Date \_\_\_\_\_

Signature (father) \_\_\_\_\_ Date \_\_\_\_\_

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