

Nebraska Rural Electric Association Youth Energy Leadership Camp Participation Form/Health Statement

Nebraska Rural Electric Association
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This form is needed to assist in identifying appropriate care. Any changes to this form should be provided to NREA camp personnel upon the participants arrival at camp. Please provide **complete** information and return it to NREA by June 7, 2024.

Please print or type

Name of Sponsoring Rural Electric System	Camper e-mail address	T-shirt size
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First Name of Camper	Middle Initial	Last Name
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Street Address	City	State	Zip
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Age	Date of Birth	Male/Female
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Emergency Contacts

Parent/Guardian	Day Phone	Night Phone
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Street Address	City	State	Zip
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Secondary Contact	Day Phone	Night Phone
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Street Address	City	State	Zip
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Parent/Guardian Authorization/Release of Liability

I hereby give permission to the medical personnel and/or physician selected by the camp to order x-rays, routine tests, treatment; and/or hospitalization; to release any records necessary for insurance purposes; and to provide or arrange necessary transportation for the person named above. The health history is correct as far as I know and the person herein described has permission to engage in all camp activities except as noted. I have read and support the Youth Energy Leadership Camp Code of Conduct. In addition I hereby release the Nebraska Rural Electric Association, its officers, members and associated organization from any and all action, causes of action, claims, damages, costs, expenses, compensation, personal injury, property loss or any other loss or injury incurred by the participant during Youth Energy Leadership Camp, July 22-26, 2024.

Parent/Guardian Signature: _____ Date: _____

I further give permission for NREA or our public power district or electric cooperative to use photographs, likenesses, and/or videotape images of my student for publicity purposes related to this activity.

Parent/Guardian Signature: _____ Date: _____

Camper Agreement/Regulations/Code of Conduct

I have read the Youth Energy Leadership Camp Regulations/Code of Conduct and I agree to abide by the expectations.

Camper Signature: _____ Date: _____

Insurance/Physician Information

Insurance Company

Policy Group Number

Name of Insured

Relationship to Camper

Insurance I.D. Number

Health History Information

General Questions: Please explain any 'yes' answers below, noting the question number. Use another sheet if necessary.

	YES	NO		YES	NO
1. Had any recent injury, illness, or infectious disease?	_____	_____	11. Have diabetes or hypoglycemia?	_____	_____
2. Have a chronic or recurring illness or condition?	_____	_____	12. Have asthma?	_____	_____
3. Been hospitalized/had surgery within the past 2 years?	_____	_____	13. Had mononucleosis in the past 12 months?	_____	_____
4. Have frequent headaches?	_____	_____	14. Ever had seizures?	_____	_____
5. Ever had a head injury and/or been knocked unconscious?	_____	_____	15. Ever had frequent ear infections?	_____	_____
6. Ever passed out, been dizzy, and/or had chest pain during or after exercise?	_____	_____	16. Wear glasses, contacts or protective eyewear?	_____	_____
7. Had heart related problem? - (high/low blood pressure, shortness of breath, murmurs, etc)	_____	_____	17. Have an orthodontic appliance being brought to camp?	_____	_____
8. Had muscular/skeletal problems? - (arthritis, hernia, recent fractures, back/ joint problems)	_____	_____	18. Have problems with sleepwalking?	_____	_____
9. Had stomach/intestinal problems? - (ulcers, jaundice, indigestion, diarrhea/constipation)	_____	_____	19. If female, have an abnormal menstrual history?	_____	_____
10. Have any skin problems? - (itching, rash, acne)	_____	_____	20. Ever had an eating disorder?	_____	_____
			21. Ever had emotional difficulties for which professional help was sought?	_____	_____

Allergies

Please list all known allergies and any reactions and management of the reaction.

Medications Being Taken

Please list all medications taken routinely. Include all over the counter or non-prescription drugs. Keep all medications in the original bottle/packaging that identifies the prescribing physician (for prescription drugs), the name of the medication, the dosage, and frequency of administration. Attach more sheets as necessary.

Can your child be given aspirin or tylenol? _____ yes _____ no

Med #1: _____ Dosage: _____ Specific times taken each day: _____

Reason for taking: _____

Other Information

Please use this space and/or attach additional sheets to provide any information about the student's behavior and physical, emotional or mental health about which the camp should be aware.
