



Energy Express Child Application

Preferred location: _____

Second choice: _____

Third choice: _____

Completing this application does not guarantee enrollment. The number of child applications we receive may exceed the number of openings we have available. If your child is offered enrollment in Energy Express, you will be notified prior to the start of the program.

Child's Name _____ Male/ Female _____

Birthdate _____ Age _____

How many years has your child attended Energy Express? _____

Custodial Parent/Guardian _____

Home Address _____

City

State

Zip

Day Phone _____

Evening Phone _____

Cell Phone _____

Email Address _____

Second Parent or Guardian _____

Home Address _____

City

State

Zip

Day Phone _____

Evening Phone _____

Cell Phone _____

Email Address _____

Directions to Home _____

School _____ Grade entering in School (Fall 2018) _____

Current Teacher's Name _____

Does your child receive services through special education? Yes _____ No _____

If yes, what kind? LD _____ PD _____ ED/BD _____ MI _____ Speech _____ Gifted _____

Other _____

Does your child receive individual or small group Title I services? Yes _____ No _____

Does your child qualify for free or reduced lunch?

Eligible for free lunch _____ Eligible for reduced lunch _____ Not eligible _____

Will your child have to miss any days during the six weeks of Energy Express? Yes ☐ No ☐

If yes, when? _____

Person to contact in case of emergency if parent/guardian can't be reached:

Name _____ Phone: _____

Name _____ Phone: _____

Can you give some time to Energy Express? Check the one (or more) that you might be able to do:

- | | |
|--------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Listen to children read | <input type="checkbox"/> Provide transportation |
| <input type="checkbox"/> Read to children | <input type="checkbox"/> Help children with projects |
| <input type="checkbox"/> Work in the kitchen/cafeteria | <input type="checkbox"/> Plan activities for parents |
| <input type="checkbox"/> Help in the office | <input type="checkbox"/> Help plan special activities for children |

Who can pick up your child from Energy Express?

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

The person will be asked to show some form of ID when picking up your child.

The Energy Express staff will ask your child questions or will use your child's written work to see if the program is working. What your child says or writes will not be recorded by his/her name but as part of an Energy Express group. Your signature gives us permission to ask your child general questions or to use his/her work. This does not affect your child's participation in Energy Express.

Parent's or Guardian's signature _____ Date _____

During Energy Express, photographs or tapes may be made of children in the program. These might be used in the newspaper, on our website, or in publicity about the program. Your signature gives us permission to use photographs or tapes of your child. Your answer does not affect your child's participation in Energy Express. Check which ones we may use:

☐ Photographs ☐ Audio Tapes ☐ Videotapes

Parent's or Guardian's signature _____ Date _____

Energy Express welcomes parents and families and hopes that you will be able to join us for some activities. When could you attend something planned for parents and families?

Please check all that apply:

☐ Morning ☐ Afternoon ☐ Evening ☐ Weekday ☐ Weekend

Health History Form: 4-H Camps, Energy Express, Events, and Activities



Provide complete information and return this form with event registration. At event arrival, update information with health personnel.

Name _____
LastFirstMiddle

Home address _____
Street addressCityStateZip

Gender: ☐ Male ☐ Female Birth date ____/____/____ Age at event _____

CUSTODIAL PARENT/GUARDIAN _____ Phone _____
Name

Home address (if different from above) _____
Street addressCityStateZip

Home phone () _____ Work phone () _____ Other () _____

SECOND PARENT OR GUARDIAN OR EMERGENCY CONTACT _____

Address _____ Phone _____
Street addressCityStateZipName

If not available in an emergency, notify _____

Relationship _____ Phone _____ Address _____
Street addressCityStateZipName

INSURANCE INFORMATION: Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name _____ Group # _____

Insurance carrier address _____ Phone number _____

ALLERGIES: List all known. Describe reaction and management of the reaction.

Medication allergies (list) _____ Food allergies (list) _____ Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc. _____

_____	_____	_____
_____	_____	_____
_____	_____	_____

PERMISSIONS: Important – This section must be completed for child to participate in Energy Express.

My child ☐ has my permission ☐ does not have my permission to participate in Energy Express

☐ should not participate in the following activities _____

I understand that while all reasonable efforts will be made to provide a safe environment, certain risks are involved. I understand the State of West Virginia, West Virginia University, its Board of Governors, officers, employees, and agents are not liable in case of accidental injury or illness. I hereby further understand that in case of serious injury or illness, I will be notified. If it is impossible to contact me, I hereby give permission for emergency treatment or surgery as the attending physician recommends.

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp

activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation in Energy Express.

Signature _____ Date _____

MEDICATIONS BEING TAKEN:

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time of this event. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person **takes NO medications** on a routine basis. *OR* ☐ This person **takes medications** as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____ Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____ Reason for taking _____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer. _____

GENERAL QUESTIONS: (Explain "yes" answers below.)

Has/does the participant:

	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to the event?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts, or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions.

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should know.

Name of family physician _____ Phone _____

Name of family dentist/orthodontist _____ Phone _____

Which of the following has the participant had?

- ☐ Measles
- ☐ Chickenpox
- ☐ German measles
- ☐ Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

Please give all dates of immunization

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Diphtheria							
<input type="checkbox"/> Pertussis							
<input type="checkbox"/> Tetanus							
<input type="checkbox"/> Polio							
<input type="checkbox"/> Typhoid							
<input type="checkbox"/> TB Mantoux Test	Date of last test				<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	

SCREENING RECORD (For staff use only)

Screened by _____

Date screened _____ Time _____ AM / PM Updates/additions to health history noted ☐ Yes ☐ No ☐ None required

Meds received _____

Current health needs identified _____

Observational notes _____

To request disability accommodations for state WVU Extension events, contact Energy Express, 766 Allen Hall, PO Box 6602, Morgantown, WV 26506-6602, phone 304-293-3855, or fax 304-293-3866.

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