



PARTICIPANT HEALTH FORM

This information is needed to ensure that your son/daughter will receive the best possible care in the event of an accident, illness or other emergency. This form should be completed and signed by a parent or guardian. Participants 18 years and older and staff may complete the form themselves. We must have a form for everyone who participates in a 4-H program, or participation will not be allowed.

Please print or type legibly. Use black ink and press hard.

I. Participant Information:

PARTICIPANT NAME	LAST	FIRST	MIDDLE INITIAL
CURRENT ADDRESS	STREET/BOX #	TOWN	STATE ZIP
()			
CURRENT PHONE NUMBER	DATE OF BIRTH		
(Optional) NAME OF INSURANCE CO.		POLICY #	

II. Parent/Guardian/Emergency Contact Information:

CUSTODIAL PARENT NAME	LAST	FIRST	MIDDLE INITIAL
CURRENT ADDRESS (If different from youth above)	STREET/BOX #	TOWN	STATE ZIP
()		()	
CURRENT PHONE NUMBER	WORK OR OTHER		
()			
PHYSICIAN'S NAME	PHYSICIAN'S PHONE NUMBER		
<i>IN THE EVENT A PARENT/GUARDIAN CANNOT BE REACHED, PLEASE CALL:</i>			
()			
NAME	TELEPHONE	RELATIONSHIP TO CHILD	

III. Medical History Summary:

(Fill in the blanks and check below.)

ILLNESS	YEAR	ILLNESS	YEAR
Asthma	___	Chicken Pox	___
Chronic Appendicitis	___	Diabetes	___
Diagnosed ADD/ADHD	___	German Measles	___
Hay Fever	___	Head Injury	___
Heart Trouble	___	Kidney Trouble	___
Measles	___	Mumps	___
Transplant	___	Tuberculosis	___
Other <i>(please specify):</i>	_____		
Mental Health	_____		
Concerns <i>(please specify):</i>	_____		

PARTICIPANT SUBJECT TO:

- Asthma
- Athlete's Foot
- Bed Wetting
- Bronchitis
- Colds
- Convulsions
- Epilepsy
- Fainting
- Hay Fever
- Headaches
- Sinus Infection
- Sleep Walking
- Sore Throat
- Stomach Upsets

(continued on next page)

IMMUNIZATIONS	YEAR
Diphtheria	_____
Polio	_____
Small Pox	_____
Tetanus Toxoid	_____
Typhoid Fever	_____
Complications from previous injury or illnesses (<i>please specify</i>): _____	

SERIOUS/ALLERGIC REACTION TO:	
Bee Stings	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>
Other drugs (<i>list</i>)	_____
Serious poison ivy/oak/sumac reactions	<input type="checkbox"/>
Food Allergies (<i>list</i>)	_____
Latex Allergies	<input type="checkbox"/>
Other (<i>list</i>):	_____

V. Additional Medical Information (please attach an additional sheet if necessary):

1. For any of the above checked, please provide details which may be helpful to staff or physician.

2. Operations or serious illnesses? *Please list or describe briefly:*

3. Is participant currently using any medication or undergoing any treatment?
 Yes No *If so, please describe:*

4. Please describe any illness within the past 12 months:

5. Has participant been exposed to a contagious disease within the past three weeks?
 Yes No *If yes, what illness and where?*

6. Does participant have any physical or other limitations which may interfere with participation in out-of-school program activities?
 Yes No *If yes, please describe:*

7. Is there any question/concern in your mind about the health of the participant?
 Yes No *If yes, a complete health examination should be secured from a physician and a signed statement from him/her stating that he/she considers it safe for the individual to participate must accompany this form.*

8. Please provide any other information which a physician or staff may find helpful:

I hereby give my permission for the above named child/youth to participate in the 4-H Youth and Family Development Programs. I have read the information contained herein, have provided the required information, and signed the permission and liability waiver. In case of emergency, I hereby give my consent for necessary examination and treatment as prescribed by an attending physician.

SIGNATURE OF PARENT/GUARDIAN

 DATE

WHITE: 4-H EXTENSION EDUCATOR COPY YELLOW: LEADER COPY PINK: PARTICIPANT COPY