



**4-H PARTICIPANT HEALTH FORM**

This information is required to ensure that your child will receive the best possible care in the event of an accident, illness, or other emergency. This form must be completed and signed by a parent or guardian. Adult volunteers and participants 18 years or older may complete the form themselves. **A completed health form is required for all 4-H participants or participation will not be allowed.**

**I. Participant Information**

**Date:** \_\_\_\_\_

NAME LAST FIRST NAME OF CLUB

ADDRESS STREET/BOX# TOWN STATE ZIP

PHONE DATE OF BIRTH

NAME OF INSURANCE CO. (OPTIONAL) POLICY #

**II. Parent/Guardian/Emergency Contact Information**

CUSTODIAL PARENT NAME LAST FIRST MIDDLE INITIAL

ADDRESS STREET/BOX# TOWN STATE ZIP

PHONE (Home) PHONE (Work) PHONE (Cell)

***In the event that a parent/guardian cannot be reached, please call:***

NAME PHONE RELATIONSHIP TO CHILD

**III. Medical History**

ILLNESS	YEAR
Asthma	_____
Chicken Pox	_____
Chronic Appendicitis	_____
Diabetes	_____
Diagnosed ADD/ADHD	_____
German Measles	_____
Hay Fever	_____
Head Injury	_____
Heart Problems	_____
Kidney Trouble	_____
Measles	_____
Mumps	_____
Transplant	_____
Tuberculosis	_____
Other (specify)	_____
Mental Health Issues (specify concerns)	_____

**PARTICIPANT IS SUBJECT TO:**

Asthma	_____
Athlete's Foot	_____
Bed Wetting	_____
Bronchitis	_____
Colds	_____
Convulsions	_____
Epilepsy	_____
Fainting	_____
Hay Fever	_____
Headaches	_____
Sinus Infections	_____
Sleep Walking	_____
Sore Throat	_____
Upset Stomach	_____

**Continues on reverse...**

**SERIOUS ALLERGIC REACTIONS**

Bee Stings \_\_\_\_\_

Poison ivy/oak/sumac \_\_\_\_\_

Latex \_\_\_\_\_

List any food allergies \_\_\_\_\_

List any drug allergies \_\_\_\_\_

**IV. Additional Medical Information (you may attach additional sheet to provide detail necessary):**

1. Any operations or serious illnesses? \_\_\_\_\_ If yes, please describe:
2. Any (current) medications or treatments? \_\_\_\_\_ If yes, please describe:
3. Any illness within the past 12 months? \_\_\_\_\_ If yes, please describe:
4. Describe any complications from previous injury/illness:
5. Any limitations effecting participation in activities? \_\_\_\_\_ If yes, please describe:
6. Do you have any question or concerns about the health of this child? \_\_\_\_\_  
*If yes, please secure a complete health examination from a physician and provide a signed physician's statement permitting participation. Attach a copy of the health statement to this form.*
7. Please provide any other information that a physician or 4-H staff may find helpful:
8. If available, please provide the name and contact information of this child's attending physician:

Physician's name	Phone
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- I agree to provide 4-H with up-to-date information regarding my child/ward's medical situation, including pre-existing conditions, allergies, change in medicines or medical status so that in case of emergency which may affect the participant's regular participation in program activities, the appropriate medical assistance can be sought.
- I understand that the volunteer leader(s) and staff of 4-H agree to hold such medical information confidential and will release said health forms only to designated medical personnel in the event of an emergency, as authorized by my signature as parent or legal guardian below.
- In the case of my child/ward's allergies or need for other necessary self-administered medical treatments, by signing this form, I agree I have been informed that medical personnel may not be on site and understand that the volunteer is not required to administer such medicines or treatments. I attest that my child/ward is able to administer all such medications him/herself or that I, as the parent or guardian, or my designated representative (18 years or over) listed here, will be on hand to administer such medications as the need arises during the course of any 4-H event or activity. **Designated representative** \_\_\_\_\_  
**Contact information** \_\_\_\_\_
- 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
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