OFFICIAL 4-H HEALTH FORM **Rev. 1-2015** County_____

Type of activity: ☐**county/area** ☐ **state** ☐ **regional** ☐ **national** (check one)

Name of event/activity_____

Participant's Name: _____
Last First M.I.

Address: _____ -_____
Street Address

_____ _____ _____
City State Zip Code

Participant is: ☐ Adult ☐ Youth ☐ Male ☐ Female _____ _____ _____
Grade Birth Date Home phone

Emergency Contact: _____ _____
Name Relationship

_____ _____
Daytime phone Evening phone

_____ _____
Cell phone Other

Health Statement (to be completed by parent, physician or adult participant)

Does the participant have any dietary restrictions? If yes, please describe:	Yes	No
Does the participant have any allergies? If yes, please describe:	Yes	No
Name of all medications:		
Name and phone number of physician:		

As parent or guardian, if my child needs medical attention, I understand every effort will be made to contact me. I hereby give permission to the medical personnel selected by the person in charge of the 4-H event to order x-rays, routine tests, treatment, release any records necessary, and to provide or arrange necessary related transportation for the person named on this form. I hereby give permission to the physician selected by the person in charge of the 4-H event to hospitalize, secure emergency treatment for, to order injection, anesthesia, and/or surgery for me or my child as named on this form. I will assume all financial obligations incurred if not covered by insurance.

_____
Signature of Parent/Guardian or Adult participant Date