

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