



NEW HAMPSHIRE 4-H ACTIVITY Youth Medical Care and Treatment Form

Name Birth Date Age Male Female County

Parent/Guardian Home Phone Cell

Home Address Office Phone

Name of Family Doctor Phone

Name of Family Dentist Phone

Health Insurance Company Policy #

Tetanus Immunization:
Date of Last Booster

If you or the doctor cannot be contacted, in emergency notify:

Name

Home Phone Cell

Medication Procedures

- All prescription drugs **MUST** be carried in the container in which they were issued (with medical orders and physician's name intact). Others will not be accepted.
- Only the exact amount of medication for the length of the event should be brought to 4-H programs and should be kept in the possession of a responsible adult during the 4-H event.

CHECK BELOW IF PARTICIPANT IS SUBJECT TO ANY OF THE FOLLOWING CONDITIONS:

- | | | | | |
|--|--------------------------------------|---|--|---|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> bronchitis | <input type="checkbox"/> ear infection | <input type="checkbox"/> heart trouble | <input type="checkbox"/> kidney disease |
| <input type="checkbox"/> asthma/respiratory problems | <input type="checkbox"/> convulsions | <input type="checkbox"/> frequent headaches | <input type="checkbox"/> home sickness | <input type="checkbox"/> seizures |
| <input type="checkbox"/> bladder disease | <input type="checkbox"/> diabetes | <input type="checkbox"/> fainting | <input type="checkbox"/> intestinal problems | <input type="checkbox"/> sleepwalking |
| allergies (please list) <input type="text"/> | | | | <input type="checkbox"/> stomach problems |

other (please specify)

PRESCRIBED TREATMENT - List any medications that you take, and what they are for. Include prescription and non-prescription (such as pain relievers, aspirin, Tylenol, asthma inhaler, etc.) PLEASE INCLUDE DOSAGES AND ANY SPECIAL INSTRUCTIONS:

My child can hold on to and administer his/her own medication. Yes No

_____ signature of parent/guardian

A staff member/chaperone may administer Benedryl, Tylenol or Motrin (acetaminophen or ibuprofen) Yes No

LIST APPROXIMATE DATE IF PARTICIPANT HAS HAD OR BEEN EXPOSED TO OR SUFFERING FROM A RECENT ILLNESS OR INJURY; Operations or Serious Injuries requiring medical treatment (specify on another piece of paper if you need to.)

My child is physically able to participate in this program including handling their project animals, if animals are involved; and in the case of the 4-H horse project, participating in mounted activities. I understand that the 4-H members will be supervised, and that if a serious illness or injury develops, medical and/or hospital care will be given; however, the sponsor is not responsible in case of accident or illness. I further understand that in case of medical emergency we will be notified. In the event that I cannot be reached, I hereby give permission to the attending physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for my child as named on this Medical Care and Treatment Form and do certify that the information set forth on this form is true and correct to the best of my knowledge. I will assume all financial obligation incurred if not covered by insurance.

Parent/Guardian Signature _____

Date

Event

Event Date(s)

to