4-H MEMBER HEALTH FORM

TEAM 501 | 4-H TEAM MEMBER HEALTH FORM

Participant Information

Full Name	Birth Date	Male ___ Female ___
Home Address	City/State/Zip	Cell Phone

Notify in case of Emergency (Emergency Contacts will be notified in order listed until one contact is reached):

Name/Relationship		Name/Relationship	
Address		Address	
City/State/Zip		City/State/Zip	
Home Phone	Cell Phone	Home Phone	Cell Phone

Food Allergies (List food)	**Life Threatening? ___YES ___NO**
Medication Allergies (List medications)	**Life Threatening? ___YES ___NO**
Insect Allergies (List Insect)	**Life Threatening? ___YES ___NO**
Other Allergies (List)	**Life Threatening? ___YES ___NO**

Personal Medical History

Tetanus Immunization/Date of Last Booster:

Current/chronic health problems, or recent surgery/hospitalization? check yes if any apply ___**YES** ___**NO**

If yes, please explain (attach another piece of paper if necessary):

Current emotional, behavioral, mental health or learning/educational challenges we should know about? ___**YES** ___**NO**

If yes, please explain and include accommodations or ways of responding that might be helpful (use another piece of paper if necessary):

Physical Limitations? ___**YES** ___**NO**

If yes, please explain and include accommodations that might be helpful (use another piece of paper if necessary):

(continued on next page)

Insurance Information

Insurance Carrier:

Insurance ID Number:

Medication

List any and all medications currently being taken. Include prescription *and* non-prescription. PLEASE INCLUDE DOSAGES

For minor participants only:

1. Will medications need to be administered during the program? **___YES ___NO** *If yes, please list all medication taken during the program and see note below**
2. I give permission for the program participant to self-administer the medication identified and that s/he has the knowledge and skills to safely use the medication. **___YES ___NO**
3. A staff member/volunteer leader may administer (check all that apply):
   ___ Benadryl (diphenhydramine) ___ Tylenol (acetaminophen) ___ Motrin (ibuprofen) ___ Antacids

*If medications must be administered to a minor during a program, ***please contact the program staff or volunteer leader to discuss specifics*** and note that:

1. All medications **MUST** be carried in the container in which they were issued, prescriptions must include medical orders and physician's name.
2. Any medications brought to 4-H events should be the exact amount required and should be kept with a responsible adult until administration, with the possible exception of Epi-Pens and Asthma Inhalers

The program participant as named on this Health and Medication Form is physically able to participate in this program including working with machinery which may be used for cutting, drilling, grinding, soldering, etc. I understand 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, that the emergency contacts listed on this form will be contacted. If the program participant named on this form is a minor, I hereby give permission in the case of a medical emergency to the attending physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for the program participant. I will assume all financial obligations incurred if not covered by insurance. I understand this form will be in the possession of the appropriate program staff or volunteer leaders.

I certify that I am the parent/guardian of the above named child (or I am 18 years of age and legally eligible to sign for myself) and that the information set forth on this form is true and correct to the best of my knowledge. I agree that I will update this form as my/my child’s condition/medications change.

Parent/Guardian Signature:	Date: