Virginia Cooperative Extension

4-H Health History Report Form *

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INSTRUCTIONS: Please provide detailed health information for determining appropriate supervision, support, and accommodations for the 4-H activity or event listed. **A parent or guardian must sign.** If the participant is a person with a disability and desires any assistive devices, services or other accommodations to participate in this activity, please contact your local Extension office during business hours at least 7 days prior to the event to discuss accommodations. **PLEASE PRINT ALL INFORMATION**. (NOTE: Both sides of this form must be completed.)

NAME OF 4-H EVENT IN WHICH YOU WISH TO PARTICIPATE:

DATE(S) OF EVENT: LOCATION:

PARTICIPANT IDENTIFICATION

NAME: _____ _____ _____ SOCIAL SECURITY #:

Last *First* *Middle* *(Optional- may be necessary in the event of hospitalization)*

Underline name by which you like to be called

MAILING ADDRESS: PARTICIPANT CELL PHONE: ( )

CITY: STATE: ZIP: HOME PHONE: ( )

AGE: BIRTHDATE: HOME EMAIL:

FEMALE: ☐ MALE: ☐

RACE: (Optional) WHITE ☐ HISPANIC ☐ BLACK ☐ AMERICAN INDIAN ☐ ASIAN ☐ MULTICULTURAL ☐

PARENT / GUARDIAN IDENTIFICATION (Place a check beside who to reach in the event of an emergency.)

❑ FATHER'S NAME: (OR GUARDIAN): FATHER'S EMAIL:

FATHER'S PHONE: DAYTIME: EVENING: CELL:

❑ MOTHER'S NAME: (OR GUARDIAN): MOTHER'S EMAIL:

MOTHER'S PHONE: DAYTIME: EVENING: CELL:

WHO HAS PRIMARY CUSTODY OF THE PARTICIPANT?

ADDRESS, IF DIFFERENT THAN CHILD:

PHYSICIAN / INSURANCE INFORMATION

FAMILY PHYSICIAN NAME: PHONE: ( )

DENTIST / ORTHODONTIST NAME: PHONE: ( )

DO YOU CARRY FAMILY MEDICAL / HOSPITAL INSURANCE?: (Check √ one) **YES** ☐ **NO** ☐

CARRIER: **POLICY ID #:**

EMERGENCY CONTACT INFORMATION (Parts 1 and 2 should be completed)

1. WHERE CAN YOU BE REACHED IN THE EVENT OF AN EMERGENCY?

   LOCATION:

   PHONE: ( ) CELL PHONE: ( )

2. IF YOU **CANNOT** BE REACHED, WHO SHOULD BE NOTIFIED?

   NAME:

   HOME PHONE: ( ) WORK PHONE: ( )

   CELL PHONE: ( ) EMAIL:

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VIRGINIA STATE UNIVERSITY

PARTICIPANT HEALTH AND MEDICAL HISTORY

(Questions 1-6 must be completed.)

1. SPECIALDIETARY NEEDS

INSTRUCTIONS: The purpose of this section is to communicate special dietary needs, food allergies, etc. for any child, teen, or adult who will be attending 4-H event.

☐ 4-H Participant (5 through 13 years old) ☐ Counselor-in-training (13 through 14 years old)

☐ Teen counselor (14 through 18 years old) ☐ Adult volunteer or Extension faculty/staff

In the space below, please list all **food allergies** for the person listed above and any necessary precautions that should be taken:

In the space below, indicate any **food restrictions (non-allergy)** for the person listed above and food substitutes that may be considered:

2. Has the participant ever experienced (or had special needs in) any of the following? [Check (✔) all that apply]

☐ Asthma ☐ Bleeding disorders ☐ Attention disorders (ADHD)
☐ Eating disorders ☐ Seizures/Convulsions ☐ Wears contacts
☐ Diabetes ☐ Bed Wetting ☐ Behavior
☐ Fainting spells ☐ Other:

Pleasedescribe any condition or need that you checked:

3. Is the participant experiencing any current health problems, under medical care, receiving mental or behavioral services, or currently taking medication?

☐ YES ☐ NO If YES, *please explain:* _____

4. Has the participant undergone surgery, or experienced any injury, illness, allergy, or change in health status any time during the last year? Is there any reason that participation in a program or activity should be restricted?

☐ YES ☐ NO If YES, *please explain:*

5. Does the participant require a special diet (including vegetarian, dietary restrictions, dietary allergies, etc.)?

☐ YES ☐ NO If YES, *please explain:*

6. What else should we know about your child?

4-H programs include very rewarding, but sometimes challenging situations. Please inform us of any concerns that may arise related to your child's physical, mental, emotional, and/or social health in order that we may better provide appropriate supervision and support.

IMMUNIZATION HISTORY

Are your child's immunizations up to date? ☐ YES ☐ NO

Date of most recent tetanus shot: (month/year) ____/____

4-H PARTICIPANT MEDIA RELEASE

I give permission for Virginia Cooperative Extension to use photographs, or video, or audio footage, or testimonials of my child for local, regional, or state publicity, or educational purposes.

☐ YES ☐ NO

APPROVAL / EMERGENCY AUTHORIZATION

(Please read parts 1 and 2. If the participant is under 18, parents/guardians must sign in the space provided. If you are over the age of 18, please sign for yourself. If you cannot sign this due to religious reasons, you must contact your Extension office to obtain a legal waiver that must be signed. **If this section is not signed, participation in the 4-H event/activity will not be allowed.** You must contact your Extension office if there is a change in health status after submitting this form.

1. I give my permission for the participant named on this form to attend the designated 4-H program. He / She has permission to participate in all activities which may include swimming and other water sports under the supervision of lifeguard(s) and to take part in other scheduled activities such as firearm safety, horsemanship, archery, low ropes, physical activity/exercise and related activities under the supervision of instructors; subject to limitations noted herein.
2. I hereby give permission to the medical staff person selected by the event/activity director to order X-rays, routine tests and treatment for my child (or for myself if I am a participant over 18 years old) as medically necessary. I also give permission for the participant to receive over-the-counter medication as needed under the guidance of the medical staff person. I understand that all attempts will be made to notify parents/guardians of any serious injury or illness to their child. If I cannot be reached in an emergency, I hereby give permission to the medical staff person to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/or the participant named on this form. This form may be photocopied for use outside of the event/activity location.

ADULT PRINTED NAME:

SIGNED: X

(Parent / Legal Guardian or participant over 18 years old)

Date:

I understand and agree to abide with the restrictions placed on my activities according to this form.

*Youth signs below **only** if there are restrictions listed on this form.*

YOUTH PRINTED NAME:

SIGNED: **X**

(Participant under 18 years old)

Date:

RELEASE AUTHORIZATION

I give permission to the following individual(s) to pickup my child at the conclusion of this 4-H event:

Name(s): , ,

Sign below at time of pickup (Receiving person must be pre-listed above)**:**

Name (print): Signature: Date: