Virginia Cooperative Extension

4-H Health History Report Form

REVISED 2002 **PUBLICATION 388-906**

* 18 U.S.C. 707

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.)

Office Use Only
Unit ______________________
Date Received: ______________________

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: ______________________ HOME PHONE: (______) ______________

CITY: ______________ STATE: _____ ZIP: __________ HOME EMAIL: ______________________

AGE: ________ BIRTHDATE: ______________ FEMALE: ☐ MALE: ☐

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

PARENT / GUARDIAN IDENTIFICATION

FATHER'S NAME: (OR GUARDIAN): ______________________

FATHER'S WORK PHONE: (________) ______________ FATHER'S WORK EMAIL: ______________

MOTHER'S NAME: (OR GUARDIAN): ______________________

MOTHER'S WORK PHONE: (________) ______________ MOTHER'S WORK EMAIL: ______________

WHO HAS PRIMARY CUSTODY OF THE PARTICIPANT? ______________________

PHYSICIAN/INSURANCE INFORMATION

FAMILY PHYSICIAN NAME: ______________________ PHONE: (________) ______________

DENTIST / ORTHODONTIST NAME: ______________________ PHONE: (________) ______________

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

CARRIER: ______________________ **POLICY/GROUP #:** ______________

EMERGENCY CONTACT INFORMATION (Parts 1 and 2 must be completed by Parent/Guardian)

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

   LOCATION: ______________________ PHONE: (________) ______________

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

   HOME ADDRESS: ______________________ HOME PHONE: (______) ______________

   CITY: ______________ STATE: ____ ZIP: ________ HOME EMAIL: ______________________

   WORK ADDRESS: ______________________ WORK PHONE: (______) ______________

   CITY: ______________ STATE: ____ ZIP: ________ WORK EMAIL: ______________________

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Virginia Cooperative Extension programs and employment are open to all, regardless of race, color, religion, sex, age, veteran status, national origin, disability, or political affiliation. An equal opportunity/affirmative action employer. Issued in furtherance of Cooperative Extension work, Virginia Polytechnic Institute and State University, Virginia State University, and the U.S. Department of Agriculture cooperating. J.David Barrett, Director, Virginia Cooperative Extension, Virginia Tech, Blacksburg; Lorenza W. Lyons, Administrator, 1890 Extension Program, Virginia State, Petersburg.
VT/643/0202/35M/222629/388906

VIRGINIA STATE UNIVERSITY

PARTICIPANT HEALTH AND MEDICAL HISTORY *(Questions 1-6 must be completed.)*

1. Does the participant have any known allergies? *(Including: food, medicine, plants, animals, insects, other)*

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

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: ____________

Please describe 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. Is there additional information essential staff should know (including behavioral/ physical/ emotional disabilities, medication instructions, and/or special restrictions) in order to identify and provide appropriate supervision, support, and accommodations for the participant?

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

IMMUNIZATION HISTORY

Immunizations received		Last year received
Tetanus	____________	____________
Diphtheria	____________	____________
Polio	____________	____________
Other	____________	____________

(For each of the following, write the date of the vaccination and/or the disease)

	Vaccination	Disease
Measles	____________	____________
Mumps	____________	____________
Rubella	____________	____________
Pertussis	____________	____________
Chicken pox	____________	____________

MEDICAL 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.

SIGNED: **X**____________________ Date: ____________

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

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

SIGNED: **X**____________________ Date: ____________

(Participant under 18 years old)

RELEASE AUTHORIZATION

I give permission for the following person(s) to pick my child up at the end of this 4-H activity.

NAME: ____________________ RELATIONSHIP TO 4-H MEMBER: ____________

NOTE: Participants will not be permitted to leave with anyone other than the person designated above.

SIGNATURE OF PERSON PICKING UP THE 4-H MEMBER: ____________________ DATE: ____________