OFFICIAL 4-H HEALTH FORM  Rev. 1-2015

Type of activity:  ☐ county/area  ☐ state  ☐ regional  ☐ national  (check one)

Name of event/activity

Participant's Name:  ___________________________  ___________________________  ___________________________

Address:  ___________________________________________  ___________________________________________

City  State  Zip Code

Participant is:  ☐ Adult  ☐ Youth  ☐ Male  ☐ Female

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