4-H Member/Volunteer Health Form

(Please Print)

Member/Volunteer Information (This form is used to ensure your safety and well being.)

Last Name	First	Middle Initial	❑ M ❑ F Sex	/ / Date of Birth

Street Address	City	State	ZIP Code	( ) Home Phone No.

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 Code	City State Zip Code
( ) Home Telephone ( ) Work Telephone ( ) Cell Telephone	( ) Home Telephone ( ) Work Telephone ( ) Cell Telephone

Allergies

Food (List Food)	Life Threatening?	❑ Yes	❑ No
Drug (List Drug)	Life Threatening?	❑ Yes	❑ No
Insect (List Insect)	Life Threatening?	❑ Yes	❑ No
Other (List)	Life Threatening?	❑ Yes	❑ No

Personal Medical History

Previous Surgery/Hospitalization? Explain	Date
Physical Impairment? Explain	Date
Mental Health Issues Requiring Treatment? Explain	Date
Current Medications and conditions for which they are prescribed?	Date
Is there any other personal medical history you feel we should know?	Date

Parent/Guardian Authorizations:

I recognize that some activities have an inherent risk that could result in personal injury. The person herein described has permission to engage in all 4-H activities except as noted. Please list here:

I hereby give permission to the medical personnel to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected to secure and administer treatment, including hospitalization, for the person named above. I (we) understand that all financial obligations incurred, if not covered by insurance, will be my responsibility. This form may be photocopied for specific special events such as sledding trips, project workshops, etc. This health form will be maintained in a confidential manner.

Signature of parent or guardian	Date
Printed Name	Date

OVER

Parent/Guardian Authorizations Continued

I, _____, affirm that due to my and/or my child's sincere religious beliefs, I/my child may not receive the following medical treatment:

_____ Certain treatment (specify):
_____
_____
_____

_____ Any Medical Treatment

I release the University of Connecticut, its Cooperative Extension System, 4-H Youth Development Program, the State of Connecticut and their agents and employees from any responsibility or impairment to me/my child's health that may result from this exemption.

Signature of Parent or Guardian Date:

Printed Name

Consent for Medication Administration

If your son, daughter or ward will be under the age of 18 while in attendance at this 4-H overnight Event, it is the University of Connecticut 4-H Program policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device can be self-administered or be administered by the on-site nurse/health professional.

All medications must be in a medicine bottle and labeled with the participant's name, doctor's name and phone number, medication name, and dosage. You must also complete the form below:

_____No medication has been brought to the 4-H overnight event.

_____ I want the medication or medical devices self administered. (Age 14 and above only.)

_____ I want the medication or medical device administered by the Nurse/Health Professional However, a limited amount of medication for life threatening conditions may be carried by my son/daughter/ward. (i.e. bee sting kits, inhalers)

Name of medication(s) Prescribing Doctor Doctor's phone number

Amount to be taken How is it taken? When to be administered

Day(s) to be taken Special Instructions

Signature of parent or guardian Date: