

**HEALTH FORM
(Youth)**

Event/Activity/Trip

County

Dorm and/or Room Number

Name

Birthdate

Street Address

City

State

ZIP code

(_____) _____
Home Phone Number

List any activities the participant should avoid (i.e., swimming):

Physical Record of Participant

Yes

No

Heart Condition

Diabetes

Polio

Convulsions

Ear Infections

Bedwetting

Allergy to any medication

List medicines allergic to: _____

Other allergies (i.e., food, dust, pollen, animals)

List other allergies _____

Date of last tetanus shot: _____

Please list any current medication being taken on reverse side of this form.

Any other medical record information that would be beneficial during the program or in an emergency:

PARENTAL AUTHORIZATION

Pursuant to Indiana Code Paragraph 16-36-1-6 and subject to any limitations listed below, I request and authorize Purdue University Cooperative Extension Service employees and their authorized agents to arrange for all reasonably necessary medical care, including transportation and hospitalization, for my child while in attendance at and participating in 4-H/Youth Development events and activities.

Parent/Legal Guardian Signature

Date

Witness to Parent/Legal Guardian

Date

Parent/Guardian Telephone: (_____) _____ (_____) _____
Home Work

Both above signatures required for acceptance to participate

In case we cannot reach you, please list the name and phone number of a second party to contact:

Name _____

Address _____

Telephone: (_____) _____ (_____) _____
Home Work

-OVER-

ADDENDUM TO THE 4-H YOUTH HEALTH FORM

Complete this form if **prescription medications** are being taken by the student at the time of the event or if **over-the-counter medication** is to be administered by a leader or chaperone.

County: _____

4-Her's Name: _____

Address: _____

Street, Route, or Box Number

City

State

Zip

Phone: Day () _____ Evening () _____

Name of Medication: _____

What Illness/Condition is this medication intended for: _____

Check one of the following:

_____ Tylenol/Ibuprofen may be administered by 4-H Youth Development event personnel

_____ Benadryl may be administered by 4-H Youth Development event personnel

_____ Medication is to be self administered by student

_____ Medication is to be administered by 4-H Youth Development event personnel

Dosage: _____ Refrigeration? Yes _____ No _____

Special Instructions: _____

Other information (if applicable): _____

Date(s) to Administer: From _____ To _____

Prescribing Doctor's Name: _____ Phone: () _____

Note: This form is to be used as a reference for 4-H participants taking any medication (prescription or "over-the-counter"). Administering of the medication is the responsibility of the participant. If health facilities and/or personnel are available at the facility and you prefer the trained personnel to administer the medication you may request this prior to the event.

Event: _____ Date (s): _____

Signature of Parent/Legal Guardian

Date

Signature of Parent/Legal Guardian

Date