

North Dakota State University 4-H Health Form



Name _____ Birth Date ____/____/____ Age _____
Last First Month/Day/Year

Parent or guardian _____

Phone: Home () _____ Office () _____ Cell () _____

Home address _____
Number & Street City State Zip

Name and phone number of family doctor _____

Health insurance company _____ Policy # _____

If you or the doctor cannot be contacted, list another adult who should be contacted in case of an emergency:

Name _____ Phone () _____

Address _____
Number & Street City State Zip

4-H Health Statement

HEALTH HISTORY (check, giving appropriate dates)

- | | |
|---|--|
| <input type="checkbox"/> Bronchitis _____
<input type="checkbox"/> Fainting _____
<input type="checkbox"/> Serious ivy, oak or sumac poisoning _____
<input type="checkbox"/> Food allergies? What? _____
<input type="checkbox"/> Asthma _____
<input type="checkbox"/> Convulsions _____
<input type="checkbox"/> Drug allergies? <input type="checkbox"/> Penicillin <input type="checkbox"/> Aspirin <input type="checkbox"/> Tetanus
<input type="checkbox"/> Serious allergies to bees or other insects? _____
<input type="checkbox"/> Others _____
<input type="checkbox"/> Reactions _____
<input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Wears glasses <input type="checkbox"/> Contact lenses _____
<input type="checkbox"/> Present special dietary needs _____
<input type="checkbox"/> Present medications/instructions _____
<input type="checkbox"/> Any specific activities to be restricted? _____
<input type="checkbox"/> Date of last Tetanus shot _____
<input type="checkbox"/> Recent medical update (including injuries and surgeries) _____ |
|---|--|

The NDSU Extension Service staff at the event may administer the following over-the-counter medication if my child needs them, without contacting me.

- | | |
|---|---|
| <input type="checkbox"/> Acetaminophen (generic Tylenol)
<input type="checkbox"/> Ibuprofen (generic Motrin) | <input type="checkbox"/> Antihistamine (generic Benedryl)
<input type="checkbox"/> Antacid (generic Tums, Mylanta, Pepto-Bismol, etc.) |
|---|---|

I understand that my health insurance is considered primary coverage in the case of illness or an accident. The 4-H program health insurance policy is secondary.

Verification

PARENT/GUARDIAN: State of North Dakota county of _____

I (parent/guardian) _____

understand that the 4-H'ers will be supervised and that, if a serious illness or injury develops, medical and/or hospital care will be given; however, the sponsor is not responsible in case of accidental injury or illness. I further understand that, in case of a medical emergency, we will be notified. In the event I cannot be reached, I hereby give permission to the attending physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for my child as named on this Health Form and do solemnly swear or affirm that the information set forth in this Health Form is true and correct to the best of my knowledge and belief.

Parent/Guardian Signature _____ Date ____/____/____

Witness _____

Witness Address and Phone Number _____

(Visit NDSU 4-H website at www.ext.nodak.edu/4h/4-h.htm)



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