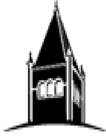

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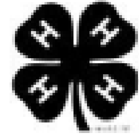

NEW HAMPSHIRE 4-H
Adult Medical Care and Treatment Form

Name: ____ Birth Date: __________ Age:______ Sex: ___________

Phone: Home _______________________________ Office(s) ____

Home Address: ____

Name of Family Doctor: ___________________________________ Phone: ____________________________________

Name of Family Dentist: ___________________________________ Phone: ____________________________________

Health Insurance Company:__________________________________ Policy #: ___________________________________

If you or the doctor cannot be contacted - in emergency notify: ____

Phone: _________________________ Address: ____

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HEALTH HISTORY: The following information is necessary for the adequate protection of all participants in the specified 4-H event/trip. This may or may not duplicate other requests for information. (Check giving appropriate dates)

LIST ANY NON-PRESCRIPTION MEDICATIONS SUCH AS PAIN RELIEVERS ASPIRIN, TYLENOL, ETC. THAT YOU TAKE:

LIST APPROXIMATE DATE IF PARTICIPANT HAS HAD OR BEEN EXPOSED TO OR SUFFERING FROM A RECENT ILLNESS OR INJURY:

Tetanus Immunization: Date of Last Booster _____________________
Operations or Serious Injuries requiring medical treatment (specify on reverse side of form):

H˙BELOW IF PARTICIPANT IS SUBJECT TO:
___ arthritis, diabetes, kidney disease, bladder disease ___ headaches, convulsions, fainting, seizures
___ respiratory problems, bronchitis, asthma controlled (y/n) ___ stomach problems, intestinal problems
___ heart trouble ___ ear infection ___ home sickness/sleepwalking ___ other (please specify)

SPECIFY ANY ITEMS CHECKED

LIST ANY ALLERGIES INCLUDING FOOD, MEDICATION, ENVIRONMENTAL, INSECTS.

Prescribed Treatment ____ Self-Treat ___Y ___ N

USE OTHER SIDE IF NECESSARY.

****

I understand if a serious illness or injury develops, medical and/or hospital care will be given; however, the sponsor is not responsible in case of accident or illness. I further understand that in case of medical emergency my physician will be notified. In the event that my physician cannot be reached, I hereby give permission to the attending physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for myself as named on this Medical Care and Treatment Form and do certify that the information set forth on this form is true and correct to the best of my knowledge. I will assume all financial obligation incurred if not covered by insurance.

Adult Participant/Volunteer Signature: ______________________________ Date: ___________________________

Event: ____ Event Date: ______________________________

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