NH 4-H Health and Medication Form

Participant Information

Full Name	Birth Date	Gender
Home Address	City/State/Zip	Home Phone

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	City/State/Zip
Home Phone Work Phone Cell Phone	Home Phone Work Phone Cell Phone

Allergies

Food Allergies (List food)	**Life Threatening?** ☐ **YES** ☐ **NO**
Medication Allergies (List medications)	**Life Threatening?** ☐ **YES** ☐ **NO**
Insect Allergies (List Insect)	**Life Threatening?** ☐ **YES** ☐ **NO**
Other Allergies (List)	**Life Threatening?** ☐ **YES** ☐ **NO**

Personal Medical History

Tetanus Immunization/Date of Last Booster:

Current/chronic health problems, or recent surgery/hospitalization? check yes if any apply ☐ **YES** ☐ **NO**

If yes, please explain (attach another piece of paper if necessary):

Current emotional, behavioral or mental health challenges we should know about? ☐ **YES** ☐ **NO**

If yes, please explain and include accommodations or ways of responding that might be helpful (use another piece of paper if necessary):

Physical Limitations? ☐ **YES** ☐ **NO**

If yes, please explain and include accommodations that might be helpful (use another piece of paper if necessary):

(continued on next page)

Medication

List any medications currently being taken. Include prescription *and* non-prescription. PLEASE INCLUDE DOSAGES

For minor participants only:

1. Will medications need to be administered during the program? ☐ **YES** ☐ **NO** *If yes, please list and see note below**

2. I give permission for the program participant to self-administer the medication identified and that s/he has the knowledge and skills to safely use the medication. ☐ **YES** ☐ **NO**

3. A staff member/volunteer leader may administer (check all that apply):
   ☐ Benadryl (diphenhydramine) ☐ Tylenol (acetaminophen) ☐ Motrin (ibuprofen) ☐ Antacids

*If medications must be administered to a minor during a program, ***please contact the program staff or volunteer leader to discuss specifics*** and note that:

1. All medications **MUST** be carried in the container in which they were issued, prescriptions must include medical orders and physician's name.
2. Any medications brought to 4-H events should be the exact amount required and should be kept with a responsible adult until administration, with the possible exception of Epi-Pens and Asthma Inhalers

The program participant as named on this Health and Medication Form is physically able to participate in this program including handling their project animals, if animals are involved. I understand 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 accident or illness. I further understand that in case of medical emergency, that the emergency contacts listed on this form will be contacted. If the program participant named on this form is a minor, I hereby give permission in the case of a medical emergency to the attending physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for the program participant. I will assume all financial obligations incurred if not covered by insurance. I understand this form will be in the possession of the appropriate program staff or volunteer leaders.

I certify that I am the parent/guardian of the above named child (or I am 18 years of age and legally eligible to sign for myself) and that the information set forth on this form is true and correct to the best of my knowledge. I agree that I will update this form as my/my child's condition/medications change.

Parent/Guardian Signature:	Date