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