HEALTH FORM
(Youth)

Attach current photo here.
Photo will not be returned.

Area VI Junior Leader Event- The Game of Life

Event/Activity/Trip

_____ _____
County Dorm and/or Room Number

_____ _____
Name Birthdate

_____
Street Address City State ZIP code

(_____)_____ _____ _____
Day Phone Number Evening Phone Number Youth Cell Number (if applicable)

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

_____

Physical Record of Participant	Yes	No
Heart Condition	___	___
Diabetes	___	___
Ear Infections	___	___
Bedwetting	___	___
Allergy to any medication	___	___
List medicines allergic to: _____		
Food allergy or dietary restrictions	___	___
List allergies/restrictions_____		
Other allergies (i.e., 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.

I also understand that, as a result of my child's participation in this program, it will be necessary for Purdue CES employees and other authorized personnel with the program to have access to relevant medical information pertaining to my child, and I authorize the use and disclosure of my child's medical information to promote a safe and healthy experience for my child.

_____ _____
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

Please complete the addendum on reverse side

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 an Extension staff member or other authorized personnel.

Medications must be carried in their original containers.

County: _____

4-H member's Name: _____

Name of Medication: _____

What Illness/Condition is this medication intended for: _____

Check all of the following that apply:

_____ 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 who require 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