

Event _____

Year _____

4-H Volunteer & Staff Emergency Medical Information

Name		County	
Street, City, State, Zip			
<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	
Emergency Contact Name & Relationship			
Home Phone		Work Phone	
Alternate Emergency Contact Name & Relationship			
Home Phone		Work Phone	

Health Information Statement

Please check items you feel event personnel may need to know to maximize your safety and well-being. Also, please list specific information on any items you have checked. Please be concise. In the event of an emergency, this form may be the only immediate source of accurate information.

- | | |
|---|---|
| <input type="checkbox"/> Nervous or Mental (epilepsy, emotional stress, convulsions)
<input type="checkbox"/> Lung Disease (asthma, persistent cough, tuberculosis)
<input type="checkbox"/> Disease of heart or blood vessels, increased or abnormal blood pressure
<input type="checkbox"/> Pain in chest or shortness of breath (heart murmur, rheumatic fever)
<input type="checkbox"/> Stomach or intestinal trouble (ulcers, gall bladder or liver disorder, jaundice, hernia, colitis)
<input type="checkbox"/> Arthritis, Diabetes, Kidney or Bladder Disease
<input type="checkbox"/> Impaired sight or hearing, chronic ear infections
<input type="checkbox"/> Recent surgical operations, accidents, or injuries
<input type="checkbox"/> Allergy to medicines (including penicillin, tetanus)
<input type="checkbox"/> Hay fever or allergies | <input type="checkbox"/> Allergy to foods
<input type="checkbox"/> Any infectious disease
<input type="checkbox"/> Skin Disease
<input type="checkbox"/> Significant orthopedic and/or neuromuscular
<input type="checkbox"/> Impairment (e.g. loss of limb, spinal cord injury)
<input type="checkbox"/> Under care of physician (give name and phone number below) for chronic recurring problem
<input type="checkbox"/> Do you wear glasses OR contact lenses (please circle which)
<input type="checkbox"/> Currently taking medication (list names and doses below)
<input type="checkbox"/> Currently taking medications which needs refrigeration
<input type="checkbox"/> Date of last TETANUS BOOSTER _____
<input type="checkbox"/> Other: _____ |
|---|---|

Please provide detailed information for any checked items above. Please be specific.

Family doctor or clinic where medical records are located: _____

City/State: _____ Phone: _____

Insurance Provider: _____ Policy # _____

Authorization

I understand that it is my responsibility to provide updates (including changes in health conditions and medical coverage) prior to the beginning of this event. I authorize each of the following:

- A. The health history and medical information I have provided is correct and I can engage in all program activities as noted. I understand that it is my responsibility to provide updates (including changes in health conditions, medical coverage, or activity restrictions) prior to any events/ activities in which I participate.
- B. If an injury or other medical condition occurs or arises, I grant permission for medical treatment to be obtained.
- C. I authorize the release of any medical treatment as deemed necessary.
- D. I understand that I am financially responsible for charges and hereby guarantee full payment to the attending physicians and/or health care unit.

Signature: _____ Date: _____