

**HEALTH FORM
(Youth)**

**Attach current photo here.
Photo will not be returned.**

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.

Please describe any current physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations that would be beneficial during 4-H participation:

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

Risk Management Forms

Reviewed and approved by OLC April 2020

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

Youth's weight: _____ lbs.

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