



# 4-H Health History Form

Provide complete information and return this form with event registration. At event arrival, update information with health personnel.

Name: \_\_\_\_\_  
Last First Middle

Home Address: \_\_\_\_\_  
Street City State Zip

Gender:  Male  Female Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age at Event: \_\_\_\_\_

CUSTODIAL PARENT/GUARDIAN: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name

Home Address (if different from above): \_\_\_\_\_  
Street City State Zip

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Other: ( ) \_\_\_\_\_

SECOND PARENT/GUARDIAN OR EMERGENCY CONTACT: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City State Zip Name

If not available in an emergency, notify: \_\_\_\_\_  
Name

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ Address: \_\_\_\_\_  
Street City State Zip

INSURANCE INFORMATION: Is the participant covered by family medical/hospital insurance?  Yes  No

If so, indicate carrier or plan name: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Carrier Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

ALLERGIES: List all known. Describe reaction and management of the reaction.

Medication allergies (list)	Food allergies (list)	Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does not eat:  Red meat  Pork  Dairy products  Poultry  Seafood  Eggs  Other (describe) \_\_\_\_\_

**PERMISSIONS: Important – This section must be completed for child to attend.**

My child:  has my permission to attend  does not have my permission to attend  
 has my permission participate in swimming  does not have my permission to participate in swimming  
 should not participate in the following activities: \_\_\_\_\_

I understand that while all reasonable efforts will be made to provide a safe environment, certain risks are involved. I understand the State of West Virginia, West Virginia University, its Board of Governors, officers, employees and agents are not liable in case of accidental injury or illness. I hereby further understand that in case of serious injury or illness, I will be notified. If it is impossible to contact me, I hereby give permission for emergency treatment or surgery as the attending physician recommends.

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as

noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICATIONS BEING TAKEN:**

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time of this event. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration.

This person takes NO medications on a routine basis. OR  This person takes medications as follows:

Med. #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_ Reason for taking \_\_\_\_\_

Med. #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_ Reason for taking \_\_\_\_\_

Med. #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_ Reason for taking \_\_\_\_\_

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer. \_\_\_\_\_

**GENERAL QUESTIONS:** (Explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to the event?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions.

# \_\_\_\_\_

# \_\_\_\_\_

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the camp should know. \_\_\_\_\_

Name of family physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of family dentist/orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

Which of the following has the participant had?	Please give all dates of immunization		Are all shots up to date per school requirements?					Yes	No
	Vaccine:	Dates: Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.	
<input type="checkbox"/> Measles	<input type="checkbox"/> Diphtheria	_____	_____	_____	_____	_____	_____	_____	
<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Pertussis	_____	_____	_____	_____	_____	_____	_____	
<input type="checkbox"/> German measles	<input type="checkbox"/> Tetanus	_____	_____	_____	_____	_____	_____	_____	
<input type="checkbox"/> Mumps	<input type="checkbox"/> Polio	_____	_____	_____	_____	_____	_____	_____	
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Typhoid	_____	_____	_____	_____	_____	_____	_____	
<input type="checkbox"/> Hepatitis B									
<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> TB Mantoux Test	Date of last test: _____					<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	

**SCREENING RECORD (For staff use only)** Screened by: \_\_\_\_\_

Date Screened: \_\_\_\_\_ Time: \_\_\_\_\_ a.m./p.m. Updates/additions to health history noted:  Yes  No  None required

Meds Received: \_\_\_\_\_

Current Health Needs Identified: \_\_\_\_\_

Observational Notes: \_\_\_\_\_

To request disability accommodations for state WVU Extension events, contact the Event Coordinator, 614 Knapp Hall, PO Box 6031, Morgantown, WV 26506-6031, phone 304-293-2696 or fax 304-293-7599. For local events, contact your county WVU Extension office.

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