WestVirginiaUniversity.
EXTENSION SERVICE

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: _____
Name

Address: _____ Phone: _____
Street *City* *State* *Zip*

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
1. Had any recent injury, illness, or infectious disease?	❑	❑
2. Have a chronic or recurring illness/condition?	❑	❑
3. Ever been hospitalized?	❑	❑
4. Ever had surgery?	❑	❑
5. Have frequent headaches?	❑	❑
6. Ever had a head injury?	❑	❑
7. Ever been knocked unconscious?	❑	❑
8. Wear glasses, contacts or protective eye wear?	❑	❑
9. Ever had frequent ear infections?	❑	❑
10. Ever passed out during or after exercise?	❑	❑
11. Ever been dizzy during or after exercise?	❑	❑
12. Ever had seizures?	❑	❑
13. Ever had chest pain during or after exercise?	❑	❑
14. Ever had high blood pressure?	❑	❑
15. Ever been diagnosed with a heart murmur?	❑	❑

	Yes	No
16. Ever had back problems?	❑	❑
17. Ever had problems with joints (e.g., knees, ankles)?	❑	❑
18. Have an orthodontic appliance being brought to the event?	❑	❑
19. Have any skin problems (e.g., itching, rash, acne)?	❑	❑
20. Have diabetes?	❑	❑
21. Have asthma?	❑	❑
22. Had mononucleosis in the past 12 months?	❑	❑
23. Had problems with diarrhea/constipation?	❑	❑
24. Have problems with sleepwalking?	❑	❑
25. If female, have an abnormal menstrual history?	❑	❑
26. Have a history of bed-wetting?	❑	❑
27. Ever had an eating disorder?	❑	❑
28. Ever had emotional difficulties for which professional help was sought?	❑	❑

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?

❑ Measles
❑ Chickenpox
❑ German measles
❑ Mumps
❑ Hepatitis A
❑ Hepatitis B
❑ Hepatitis C

Please give all dates of immunization

Vaccine:	Dates: Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.
❑ Diptheria	_____	_____	_____	_____	_____	_____
❑ Pertussis	_____	_____	_____	_____	_____	_____
❑ Tetanus	_____	_____	_____	_____	_____	_____
❑ Polio	_____	_____	_____	_____	_____	_____
❑ Typhoid	_____	_____	_____	_____	_____	_____

❑ TB Mantoux Test Date of last test: _____ ❑ Positive ❑ 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.