NC 4-H Youth Development
Health History & Authorization Form

NC STATE EXTENSION

4-H Group / County: _____ **Year:** _____ **(Must be updated each year)**

4-H'ers Name: _____
Last Name *First Name* *Middle Initial*

Birth Date_____/_____/_____ Age as of Jan. 1_____ Gender: ☐ Female ☐ Male Email: _____

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

Custodial Parent/Guardian Name: _____ Phone: (____) _____

Second Parent/Guardian or Emergency Name: _____

Address: _____ Phone: (____) _____

If not available in an emergency, notify (Name): _____

Relationship: _____ Phone: (____) _____

Health History

The following information should be filled in by the parent/guardian, or adult. Update required annually. For residential camp attendance, health exam must be completed by an approved licensed medical personnel within 24 months of participation in the camp. The intent of this information is to provide NC 4-H health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to NC 4-H. Provide complete information so that the NC 4-H can be aware of your needs.

MEDICATIONS

Please list **ALL** medications, even over-the-counter or nonprescription drugs, including Tylenol, Pepto-Bismol, Benadryl, etc. that may be taken. If attending out of county events, bring enough medication to last the entire time you are away. Keep it in the original packaging/bottle that identifies the prescribing physician (if prescription drug), the name of medication, the dosage, and the frequency of administration.

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

Med#1_____ Reason _____ Dosage_____ Time taken _____
Med#2_____ Reason _____ Dosage_____ Time taken _____
Med#3_____ Reason _____ Dosage_____ Time taken _____
Med#4_____ Reason _____ Dosage_____ Time taken _____

This person may take the following medications as needed:
☐ Aspirin ☐ Tylenol ☐ Ibuprofen ☐ Benadryl ☐ Pepto-Bismol ☐ Other_____

Known allergies to foods, drugs, insect stings or bites, etc: _____

Restrictions - The following restrictions apply to this individual:

Dietary

☐ Vegetarian
☐ Vegan
☐ Other (describe)_____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary): _____

General Questions (Explain "yes" answers.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	☐	☐	13. Ever had high blood pressure?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐	14. Ever been diagnosed with a heart murmur?	☐	☐
3. Ever been hospitalized?	☐	☐	15. Ever had back problems?	☐	☐
4. Ever had surgery?	☐	☐	16. Ever had joint problems?	☐	☐
5. Have frequent headaches?	☐	☐	17. Have any skin problems?	☐	☐
6. Ever had a head injury?	☐	☐	18. Have diabetes?	☐	☐
7. Ever been knocked unconscious?	☐	☐	19. Have asthma?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐	20. Had mononucleosis in the past 12 months?	☐	☐
9. Ever had frequent ear infections?	☐	☐	21. Have problems sleepwalking?	☐	☐
10. Ever been dizzy/passed out during or after exercise?	☐	☐	22. Have a history of bed wetting?	☐	☐
11. Ever had seizures	☐	☐	23. Ever had an eating disorder?	☐	☐
12. Ever had chest pain during or after exercise?	☐	☐			

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

_____

_____

Special medical concerns or conditions that event supervisors should know about, including contagious illnesses, epilepsy, asthma, diabetes, previous injuries to bones/joints, etc: _____

_____

Which of the following has the participant had?

☐ Measles
☐ Chicken pox
☐ German measles
☐ Mumps
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C

TB Mantoux Test Date of last test_____
Result: ☐ Positive ☐ Negative

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the NC 4-H should be made aware. _____

_____

_____

Name of family physician: _____ Phone: (____) _____

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

Name of family dentist/orthodontist: _____ Phone: (____) _____

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

Insurance Information

The 4-H program purchases accident insurance for youth participants for many sponsored events. This coverage is not a substitute for personal health insurance, and may not cover all accident or medical expenses. Therefore, medical providers may find it necessary to bill the family or your insurance company for medical services rendered. Please provide the following information:

Health Insurance Company _____

Health Insurance Policy # _____

Company Address _____

Company Telephone Number (_____) _____

Authorization Form

Custody Release: You may be asked to produce photo ID at check-out. This is for your child's safety. Please be aware of this policy before picking up your child. I hereby give permission for my child, _____, to be allowed to leave the 4-H program after the activity. My child will be released into the custody of:

_____

(Names of Individuals authorized to pick up your child)

If it is necessary for my child to leave before the end of the program due to illness, injury, or behavioral issues, and I cannot be reached, I hereby give permission for my child to be released into the custody of:

_____

(Emergency contact or other individual authorized to pick up your child)

For 4-H Use Only: 4-H'er picked up by:_____Staff Signature_____

Parent/Guardian Authorization: This health history is correct and complete as far as I know. The person herein described has permission to engage in all 4-H activities except as noted.

I hereby give permission to the NC 4-H 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 NC 4-H to arrange necessary related transportation for me/my child.

The person herein described has permission to engage in all 4-H activities except as noted here: _____

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by NC 4-H to secure and administer treatment including hospitalization, for the person named above. This completed form may be photocopied for trips out of county.

Signature of parent/guardian, or adult camper/staffer: _____

Printed Name: _____ Date:_____

Health Care Recommendations by Licensed Medical Personnel for 4-H Camp Participants Only

I examined this individual on _____. BP_____ Wt _____ Ht_____
In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.
Restrictions/Recommendations:_____

_____

_____

Treatment to be continued at camp or medications to be administered at camp (name, dosage, frequency)

_____

_____

Additional information for health care staff at camp: _____

_____

_____

Signature of Licensed Medical Personnel:_____ Date:_____

Printed:_____ Title:_____

Address:_____ Phone: (___) _____
Street City State Zip Code

Please give dates of immunizations for:
(Immunization records may be attached to this form)

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Ry
DTP				
TD (tetanus/diphtheria)				
Tetanus				
Polio				
MMR				
Or Measles				
Or Mumps				
Or Rubella				
Haemophilus influenzae				
Hepatitis B				
Varicella (chicken pox)				

Screening Record: For camp use only Date_____ Time_____

Meds received_____

Updates/additions to Health History_____

Current Health needs identified_____

Screened by_____