

Note to 4-H Club Leader: This form to be retained and filed confidentially with 4-H Club Leader Files

Thurston County 4-H Club Program
PARTICIPANT HEALTHFORM

Page 1/2

Mail this form to the address below by _____ (date)

4-H Club Leader Address:

Attendance dates: from: October 1, 2011 to September 30, 2012

Participant Name: _____
First Middle Last

Male Female Birth Date _____ Age on arrival at program _____
Month/Day/Year

To Parent(s)/Guardian(s): Please follow the instructions below. Attach additional information if needed.

1. Complete pages 1 and 2 of this form (and make a copy for yourself).
2. Send the original, signed form to program by requested date.

Participant Name:

First

Middle

Last

(For Camp Use) Cabin or Group _____

(For Program Use) Session Code(s) _____

Participant Home Address: _____
Street Address City State Zip Code

Parent/guardian with residential placement and/or decision-making authority in the event of illness or injury:

Name: _____ Relationship to Participant: _____

Preferred Phones: (_____) _____ (_____) _____ Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Participant: _____

Preferred Phones: (_____) _____ (_____) _____ Email: _____

Additional parent/guardian to be contacted in case of illness or injury:

Name: _____ Relationship to Participant: _____

Preferred Phones: (_____) _____ (_____) _____ Email: _____

Allergies: No known allergies. This participant is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please describe below what the participant is allergic to and the reaction seen, in detail. Please describe preventative or responsive measures.)
 This participant has a life-threatening allergy. An emergency care plan signed by physician is required.

Diet, Nutrition: This participant eats a regular diet. This participant eats a vegetarian diet (describe details below).
 This participant has special food needs. *(Please describe below.)*

Immunizations:

- My child is up-to-date on his/her immunizations and tetanus shots as required by Washington State law.
- My child has an immunization exemption on file with his/her school. I understand and accept the risks to my child from not being fully immunized.

Medication:

We will be unable to administer medication to children. If your child requires a dosage during activity/event hours, please make appropriate arrangements. Medication¹ is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **All medications must be in their original containers. Prescriptions must have the child's name and how the medication should be given printed on the prescription container. Please send only those medications that are necessary.**

Medications Currently being taken: (must list)

- This participant will not take any daily medications while attending the activities.
- This participant will be **self-administering** the following daily medication(s) while attending the activities.¹

¹ Note: These provisions regarding administration of medication shall not abrogate minors' rights to provide their own consent to certain services under Washington law.

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PARTICIPANT HEALTH FORM

PAGE 2/2

Participant Name: _____
First Middle Last
 Birth Date: _____
Month/Day/Year

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does this participant:

- | | | | |
|----------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 1. Ever been hospitalized?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Ever had surgery?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Ever had back/joint problems?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Had a recent infectious disease?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Have problems with diarrhea/constipation?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Had a recent injury?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Have any skin problems?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Has asthma/wheezing/shortness of breath?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Traveled outside the country in the past 9 months?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have diabetes?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Had Sickle Cell disease or traits?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Had seizures?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Had high blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Had headaches?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Had cardiovascular disease or other heart problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 21. Have a history of heart disease (not limited to conjunctive heart defect, cardiomyopathy, ahbrythemia?)..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Had fainting or dizziness?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

- Restrictions:**
- I have reviewed the program and activities of the program and feel the participant can participate without restrictions.
 - I have reviewed the program and activities of the program and feel the participant can participate with the following restrictions or adaptations. **(Please describe below.)**

Does the participant require reasonable accommodation for a disability in order to access or be part of the activities?

What Have We Forgotten to Ask? Please provide in the space below any additional information about the participant's health that you think important or that may affect his or her ability to fully participate in the program. **Attach additional information if needed.**

This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all program activities except as set forth by me and/or an examining physician. If you fail to advise WSU of a medical condition, WSU is not responsible for related injuries. I understand the information on this form will be shared on a "need to know" basis with WSU staff and volunteers. I give permission to photocopy this form. In addition, the health care provider has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial _____ Relationship to Participant: _____

Parent/Guardian: _____ Date: _____

Parent/Guardians: Keep a copy for your records.