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
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 been dizzy/passed out during or after exercise?	☐	☐
11. Ever had seizures	☐	☐
12. Ever had chest pain during or after exercise?	☐	☐

	Yes	No
13. Ever had high blood pressure?	☐	☐
14. Ever been diagnosed with a heart murmur?	☐	☐
15. Ever had back problems?	☐	☐
16. Ever had joint problems?	☐	☐
17. Have any skin problems?	☐	☐
18. Have diabetes?	☐	☐
19. Have asthma?	☐	☐
20. Had mononucleosis in the past 12 months?	☐	☐
21. Have problems sleepwalking?	☐	☐
22. Have a history of bed wetting?	☐	☐
23. Ever had an eating disorder?	☐	☐

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:____________