2018 National 4-H Conference

Health & Medical Emergency Form

Complete and return this form to your state 4-H office or the adult advisor chaperoning the state delegation to the conference.

|  |  |  |  |
| --- | --- | --- | --- |
| Participant’s First Name: |  | Last: |  |
| Date of Birth: | / |  / |  |  | Gender: | [ ]  Male | [ ]  Female |
| Insurance Provider: |  |  | Insurance Policy #: |  |

Current Health

* Have you recently had, or do you have any of the following? (Check Yes or No)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | YES\* | NO |  |  | YES\* | NO |
| Asthma | [ ]  | [ ]  |  | Skin Disease | [ ]  | [ ]  |
| Tuberculosis | [ ]  | [ ]  |  | Heart or Cardiovascular Disease*(heart murmur, abnormal blood pressure, etc.)* | [ ]  | [ ]  |
| Allergies or Hayfever | [ ]  | [ ]  |  | Epilepsy (seizures) | [ ]  | [ ]  |
| Arthritis | [ ]  | [ ]  |  | Fainting | [ ]  | [ ]  |
| Diabetes | [ ]  | [ ]  |  | Emotional or Mental(anxiety, depression, paranoia, etc.) | [ ]  | [ ]  |
| Kidney or Bladder Disease | [ ]  | [ ]  |  | Impaired sight or hearing | [ ]  | [ ]  |
| Stomach or intestinal issues (ulcers, gall bladder, etc.) | [ ]  | [ ]  |  | Menstrual disorder | [ ]  | [ ]  |

\* If you answered "*yes"* to any of the above, please provide details in the space provided – to include diagnosis, date of illness, name of hospital, length of hospitalization, name of doctor, etc., as applicable.

|  |
| --- |
|  |

* Do you have allergic reactions to any of the following? (Check Yes or No)

|  |  |  |  |
| --- | --- | --- | --- |
|  | YES\* | NO | EXPLAIN: |
| Medications (penicillin, sulfates, etc.) | [ ]  | [ ]  |  |
| Plants, Trees (poison ivy, oak, etc.) | [ ]  | [ ]  |  |
| Insect bites (bee stings, ants, etc.) | [ ]  | [ ]  |  |
| Food | [ ]  | [ ]  |  |
| Other: | [ ]  | [ ]  |  |

* List any other special needs or concerns not already addressed:

|  |
| --- |
|  |

* Does the participant have a current TETANUS vaccination (*within the past 10 years*)? [ ]  YES [ ]  NO
* Has the participant had an INFLUENZA vaccination within the past 6-7 months? [ ]  YES [ ]  NO

Emergency Contact Information

|  |  |  |
| --- | --- | --- |
| **Parent/Guardian #1** |  | **Parent/Guardian #2:** |
| Name: |  |  | Name: |  |
| Relationship: |  |  | Relationship: |  |
| Home Phone: |  |  | Home Phone: |  |
| Work Phone: |  |  | Work Phone: |  |
| Cell Phone: |  |  | Cell Phone: |  |

|  |
| --- |
| **Other Emergency Contact:** |
| Name: |  |
| Relationship: |  |
| Home Phone: |  |
| Cell Phone: |  |

Consent TO medical Treatment

The participant (named above) and/or the parents/legal guardians thereof, affirm that the participant can safely take part in the National 4-H Conference and that he/she has no contagious or communicable diseases. Also, he/she has had no major illnesses within 30 days prior to attending this event.

In case of emergency while participating in the National 4-H Conference, permission is given for appropriate medical personnel and/or licensed physicians to provide medical treatment. If necessary, given apparent medical condition, permission is given to transport the participant by ambulance, aid car, or program vehicle, to a medical facility for evaluation and treatment. This authority to act on behalf of the participant shall not be effected as a medical proxy, and I/we understand the National 4-H Conference will attempt to contact the designated emergency contact and/or parents/legal guardian before authorizing such medical treatment. Further, it is understood that the participant and/or the parent/legal guardian will assume all financial obligations that may be incurred and not covered by the participant’s health insurance.

I have carefully read this document, understand its contents and am fully informedabout theactivities/events scheduled as part of the National 4-H Conference that may involve certain risks associated with physical activity or potential harm, including but not limited to recreational games/activities and travel by motor vehicle to off-site educational and leisure activities.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Participant’s Name *(print)* |  | Participant’s Signature |  | Date |
|  |  |  |  |  |
| Parent/Guardian’s Name *(print)* |  | Parent/Guardian’s Signature |  | Date |

*Youth (under age 18)* ***must*** *have signature of parent/guardian.*