

# NC 4-H Youth Development

# Health History & Authorization Form

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? 🞎 🞎

 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? 🞎 🞎

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.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 ( )

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:

**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

# Authorization Form

**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