North Carolina 4-H Youth Development
Youth Health History & Authorization Paper Form

Member Name: _____
First Name *Last Name* *Middle Initial* *Preferred Name (if needed)*

Birth Date:_____/_____/_____

HEALTH HISTORY

The following information should be completed by the parent/guardian, or adult. The intent of this information is to provide NC 4-H the background to provide appropriate care and to assist health care personnel in the case of an emergency. Any changes to this form should be provided to NC 4-H. The 4-H Health History form is **required annually**. Provide complete information so that the NC 4-H can be aware of your needs.

Note: *Youth who register to attend a "Residential 4-H Camp" must have a health exam completed by an approved licensed medical personnel within 24 months of camp participation and submit the completed "Health Care Recommendations by Licensed Medical Personnel for 4-H Camp Participants form."*

EXPOSURE: Has the participant previously had:

Chicken Pox: ☐ Yes ☐ No **Measles:** ☐ Yes ☐ No **Tuberculosis:** ☐ Yes No ☐

List Any Other Infectious Exposure (if yes, provide details): ☐ Yes ☐ No

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VACCINATIONS

Date of last Flu Shot: _____ **Date of last Tetanus Shot:** _____

CARE: Please complete this section with the participant's medial and dental physician information. *This information will only be utilized if there is a medical / dental emergency.

Primary Physician Name: _____ **Primary Physician Phone:** _(____)_____

Clinic Address:_____

Dentist Name: _____ **Dentist Phone:** _(____)_____

REMARKS: List any adaptations needed due to a disability (explain "yes" answers). ☐ Yes ☐ No

_____

_____

HISTORY: Does this participant's medial history include any of the following (explain "yes" answers):

Acute Chronic Illness: ☐ Yes ☐ No **Concussions:** ☐ Yes ☐ No **Activity Restrictions / Limitations:** ☐ Yes No ☐

Had a recent injury, illness or infectious disease : ☐ Yes ☐ No **Ever been hospitalized or had surgery:** ☐ Yes ☐ No

HEALTH INSURANCE: The 4-H program purchases 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:

Company Name: _____ **Policy / Group Number:** _____

CONDITIONS: Has or does the participant:

Have ADD-ADHD? ☐ Yes ☐ No

Have Anxiety? ☐ Yes ☐ No

Have Arthritis? ☐ Yes No ☐

Have Asperger's? ☐ Yes ☐ No

Have Asthma? ☐ Yes No ☐

Ever had an Auto-Immune Disease? ☐ Yes No ☐

Ever had back problems? ☐ Yes ☐ No

Ever had Chest Pain During or After Exercise? ☐ Yes ☐ No

Ever had Joint problems? ☐ Yes No ☐

Ever had Convulsion or Seizures? ☐ Yes No ☐

Have Diabetes? ☐ Yes No ☐

Ever had Dizziness During or After Exercise? ☐ Yes No ☐

Ever had Frequent Infections? ☐ Yes ☐

Ever had an Eating Disorder? ☐ Yes ☐ No

Have a history of Bed Wetting? ☐ Yes No ☐

Ever Been Dizzy / Passed Out During or After Exercise? ☐ Yes No ☐

Have Frequent Headaches? ☐ Yes No ☐

Ever had a Head Injury? ☐ Yes ☐ No

Ever been diagnosed with a Heart Murmur? ☐ Yes ☐ No

Had Hepatitis A, B or C? ☐ Yes ☐ No

Have Hypertension? ☐ Yes No ☐

Had Mononucleosis in the past 12 months? ☐ Yes No ☐

Had Mumps? ☐ Yes ☐ No

Ever had a Nervous Disorder? ☐ Yes No ☐

Have frequent Nose Bleeds? ☐ Yes No ☐

Sleep Walk? ☐ Yes ☐ No

Ever had a Mental Disorder? ☐ Yes No ☐

Have Migraines? ☐ Yes No ☐

Have Skin Problems? ☐ Yes ☐ No

Have Stomach Problems? ☐ Yes No ☐

List any Program Activity Restrictions or Limitations (e.g. what cannot be done, what adaptions or limitations are necessary.

☐ Yes No ☐ Explain "yes" answers.

DEVICES:

Wear Contact Lenses? ☐ Yes No ☐

Epi-Pen (provide details)? ☐ Yes ☐ No

Wear Glasses or Protective Eye-Wear? ☐ Yes No ☐

Hearing Aid? ☐ Yes ☐ No

Inhaler (provide details)? ☐ Yes ☐ No

List Any Other Devices (provide details)? ☐ Yes ☐ No

_____

_____

_____

_____

ALLERGIES: Please list known allergies here:

Aspirin ☐ Yes ☐ No **Insect Stings** ☐ Yes ☐ No **Dairy** ☐ Yes No ☐ **Eggs** ☐ Yes No ☐

Gluten ☐ Yes ☐ No **Nuts** ☐ Yes ☐ No **Peanuts** ☐ Yes No ☐ **Penicillin** ☐ Yes No ☐

Shellfish ☐ Yes ☐ No **Soy** ☐ Yes ☐ No **Sulfa** ☐ Yes No ☐ **Sunscreen** ☐ Yes No ☐

Tetanus Vaccine ☐ Yes ☐ No **Wheat** ☐ Yes ☐ No

List any additional allergies here: ☐ Yes No ☐ **List any other Dietary Considerations here:** ☐ Yes No ☐

_____

_____

AUTHORIZED MEDICATIONS: The following over-the-counter, non-prescription, medications can be administered to my child, without contacting me.

Acetaminophen ☐ Yes ☐ No **Antacid** ☐ Yes ☐ No **Antibiotic Ointment** ☐ Yes No ☐ **Antihistamine** ☐ Yes No ☐

Aspirin ☐ Yes ☐ No **Ibuprofen** ☐ Yes ☐ No **Imodium** ☐ Yes No ☐

Insect Bite /Sting Medication ☐ Yes No ☐ **Insect Repellant** ☐ Yes No ☐ **Pepto Bismol** ☐ Yes No ☐

Sunscreen ☐ Yes No ☐

MEDICAL RELEASE

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 North Carolina 4-H Youth Development Program to administer authorized / 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 the North Carolina 4-H Youth Development Program to arrange necessary related transportation for the person herein described.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by North Carolina 4-H Youth Development Program to secure and administer treatment including hospitalization, for the person herein described. This completed form may be photocopied for trips out of county or state.

Member Name: _____

Parent / Guardian Name: _____

☐ **Yes, I consent**

☐ **No, I do NOT consent**