West Virginia University
EXTENSION SERVICE

4-H Health Form

Provide complete information and return this form with event registration. At event arrival, update information with health personnel.

PARTICIPANT INFORMATION

Name: _____
Last *First* *Middle*

Home Address: _____
Street *City* *State* *Zip*

Gender: ☐ Male ☐ Female Birth Date: _____ / _____ / _____ Age at Event: _____

Custodial Parent/Guardian: _____
Name

Home Address (if different from above): _____
Street *City* *State* *Zip*

Home Phone: ( )_____ Cell Phone: ( )_____ Other: ( ) _____

EMERGENCY CONTACT INFORMATION

Name 1: _____ Relationship: _____

Home Phone: ( )_____ Cell Phone: ( )_____ Other: ( ) _____

Name 2: _____ Relationship: _____

Home Phone: ( )_____ Cell Phone: ( )_____ Other: ( ) _____

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, name of insurance company: _____ Group #:_____

Name on Insurance Card: _____ Phone: _____

PHYSICIAN INFORMATION

Physician's Name: _____ Phone: _____

ALLERGY INFORMATION

Do you have any allergies? ☐ Yes ☐ No

If yes, do you carry epinephrine, such as an Epi-Pen? ☐ Yes ☐ No

If yes, have you ever been hospitalized for these allergies? ☐ Yes ☐ No

Describe your allergies, including severity and other pertinent information: _____

_____

_____

_____

MEDICATION INFORMATION

Medication can only be dispensed from its original conainer. Ziploc bags, other bottles, bottles printed with someone else's name or any other type of container besides the original will not be accepted. Medication must be clearly labeled with the participant's name, medication name, dosage and instructions. Medications must and will be administered according to the actual dosage listed on the bottle, unless there is a written note from the prescribing physician outlining different instructions for the administration of medications.

My child will be taking the following medications during this event:

Name of medication	Date started	Reason for taking it	When it is given	Amount/dose given	How it is given

I give permission for common over-the-counter (non-prescription) medication and health care items to be administered to my child as needed to manage illness and injury. ☐ Yes ☐ No

OTHER PERTINENT HEALTH INFORMATION

Does your child have any mental health needs that may interfere with them fully participating in this program?

_____

_____

_____

Is there any additional information about your child's health that you think is important or that may impact their ability to participate in this event or program?

_____

_____

_____

ACCURACY STATEMENT

I understand that while all reasonable efforts will be made to provide a safe environment, certain risks are involved. I understand the state of West Virginia, West Virginia University, its Board of Governors, officers, employees and agents are not liable in case of accidental injury or illness. I hereby further understand that in case of serious injury or illness, I will be notified. If it is impossible to contact me, I hereby give permission for emergency treatment or surgery as the attending physician recommends.

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp 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 the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian: _____ **Date:** _____