

North Dakota State University 4-H Health Form



Name _____ Birth Date ____/____/____ Age ____
Last First Month/Day/Year

Parent or guardian _____

Phone: Home () _____ Office () _____ Cell () _____

Home address _____
Number and Street City State Zip

Name and phone number of family doctor _____

Health insurance company _____ Policy # _____

If you or the doctor cannot be contacted, list another adult who should be contacted in case of an emergency:

Name _____ Phone () _____

Address _____
Number and Street City State Zip

4-H Health Statement

HEALTH HISTORY (check, giving appropriate dates)

- Bronchitis _____
- Fainting _____
- Serious ivy, oak or sumac poisoning _____
- Food allergies? What? _____
- Asthma _____
- Convulsions _____
- Drug allergies? Penicillin Aspirin Tetanus
- Serious allergies to bees or other insects? _____
- Others _____
- Reactions _____
- Diabetes _____
- Wears glasses Contact lenses _____
- Present special dietary needs _____
- Present medications/instructions _____
- Any specific activities to be restricted? _____
- Date of last Tetanus shot _____
- Recent medical update (including injuries and surgeries) _____

The NDSU Extension Service staff at the event may administer the following over-the-counter medication if my child needs them, without contacting me.

- Acetaminophen (generic Tylenol)
- Antihistamine (generic Benedryl)
- Ibuprofen (generic Motrin)
- Antacid (generic Tums, Mylanta, Pepto-Bismol, etc.)

I understand that my health insurance is considered primary coverage in the case of illness or an accident. The 4-H program health insurance policy is secondary.

Additional information on the other side

Verification

PARENT/GUARDIAN: State of North Dakota county of _____

I (parent/guardian) _____

understand that the 4-H'ers will be supervised and that, if a serious illness or injury develops, medical and/or hospital care will be given; however, the sponsor is not responsible in case of accidental injury or illness. I further understand that, in case of a medical emergency, we will be notified. In the event I cannot be reached, I hereby give permission to the attending physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for my child as named on this Health Form and do solemnly swear or affirm that the information set forth in this Health Form is true and correct to the best of my knowledge and belief.

Parent/Guardian Signature _____ Date ____/____/____

Witness _____

Witness Address and Phone Number _____

Visit North Dakota 4-H on-line at www.ndsu.edu/4h

For more information on this and other topics, see www.ag.ndsu.edu

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