PB728

NDSU EXTENSION SERVICE
County Commissions, North Dakota State University and U.S Department of Agriculture Cooperating
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NDSU Extension Service
Health Statement for 4-H Adults

18 U.S.C. 707

Name of 4-H Program or Event_____

Name of 4-H Adult Male/Female_____

Home Address_____
No. & Street City State Zip

County_____ Birth date _____/_____/_____

Person to contact in an emergency_____ Day Phone _____

Home Address _____ Night Phone _____

Medical History of 4-H Adult

Do you have a problem with any of the following? If the answer to any item 1-16 is 'yes,' enter details on the line following the question or after #20.

Yes	No		
❑	❑	1.	Nervous or mental: problems such as epilepsy, emotional stress, convulsion, loss of consciousness, dizziness, paralysis, frequent anxiety, excessive crying_____
❑	❑	2.	Lung disease: asthma, blood spitting, persistent cough, tuberculosis, abnormal chest X-rays_____
❑	❑	3.	Disease of heart or blood vessels: increased or abnormal blood pressure _____
❑	❑	4.	Pain in chest or shortness of breath: heart murmur, rheumatic fever _____
❑	❑	5.	Stomach or intestinal trouble: ulcers, gall bladder or liver disorder, jaundice, hernia, colitis _____
❑	❑	6.	Arthritis, diabetes, kidney or bladder disease_____
❑	❑	7.	Hay fever or allergies _____
❑	❑	8.	Allergy to medicines, including penicillin _____
❑	❑	9.	Impaired sight or hearing, chronic ear infections_____
❑	❑	10.	Recent surgical operations, accidents or injuries_____
❑	❑	11.	Been a patient in a hospital (other than #10)_____
❑	❑	12.	Any infectious disease or contact with infectious disease in the two weeks prior to this trip _____
❑	❑	13.	Skin disease _____
❑	❑	14.	Allergy to foods _____
❑	❑	15.	Currently taking medicines (list names and doses) _____
❑	❑	16.	Under on-going care of a physician for chronic or recurring problem_____
❑	❑	17.	Date of last flu shot_____
❑	❑	18.	Date of last tetanus booster_____
❑	❑	19.	Do you wear glasses? Contacts?_____
❑	❑	20.	Addresses where medical records are kept on file_____

_____
No. & Street City State Zip Phone

Physician _____ Phone *(if different from above)*_____

To my knowledge I have no health problems, unless stated above, and can SAFELY PARTICIPATE in the activity identified, and that I have no contagious or communicable disease. My health is POOR, FAIR, GOOD (strike out words which do not apply) and I have had no illness within 30 days before departure. In case of emergency while participating in the 4-H event, permission is given for physicians to perform medical treatment. I will assume all financial obligations incurred if not covered by insurance.

Adult's Signature_____ Date _____/_____/_____

Name of Your Family Health Insurance Company _____

Policy Number _____