



NDSU Extension Service Health Statement for 4-H Adults



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 _____