4-H Member/Volunteer Health Form

(Please Print)

Member/Volunteer Information (This form is used to ensure your safety and well being.)

Last Name	First	Middle Initial	❑ M ❑ F ❑Non Binary ❑Other Gender	/ / Date of Birth

Street Address	City	State	ZIP Code	( ) Home Phone No.

Notify in Case of Emergency (Emergency Contacts will be notified in order listed until one contact is reached)

Name Relationship	Name Relationship
Address	Address
City State Zip Code	City State Zip Code
( ) Home Telephone ( ) Work Telephone ( ) Cell Telephone	( ) Home Telephone ( ) Work Telephone ( ) Cell Telephone

Allergies

Food (List Food)	Life Threatening?	❑ Yes	❑ No
Drug (List Drug)	Life Threatening?	❑ Yes	❑ No
Insect (List Insect)	Life Threatening?	❑ Yes	❑ No
Other (List)	Life Threatening?	❑ Yes	❑ No

Personal Medical History

Previous Surgery/Hospitalization? Explain	Date
Physical Impairment? Explain	Date
Mental Health Issues Requiring Treatment? Explain	Date
Current Medications and conditions for which they are prescribed?	Date
Is there any other personal medical history you feel we should know?	Date

Parent/Guardian Authorizations:

I recognize that some activities have an inherent risk that could result in personal injury. The person herein described has permission to engage in all 4-H activities except as noted. Please list here:

During the program, I hereby give permission for the Program Staff to administer appropriate medical attention to my child/ward in the event of any accident, illness or injury, including non-prescription medications or any medications my child brings in original containers with dosage instructions that is provided to program staff. In the event of an emergency, 911 will be called and I will be responsible for any and all costs of medical coverage and treatment provided not covered by my child's insurance.

Insurance Provider:	Insurance Policy Number:

Signature of parent or guardian	Date
Printed Name	Date

OVER

Consent for Medication Administration

If your child or ward will be under the age of 18 while in attendance at 4-H, it is the University of Connecticut 4-H program policy to secure your consent for medication distribution and for the use of medical devices. The medication or medical device can be self-administered or be administered by the on-site professional staff.

All medications must be in a medicine bottle and labeled with the participant's name, doctor's name and phone number, medication name, and dosage. You must also complete the form below:

_____No medication has been brought to the 4-H overnight event.

_____ I want the medication or medical devices self-administered. (Doctors note required for youth 13 and under.)

_____ I want the medication or medical device administered by the on-site program provider. However, a limited amount of medication for life threatening conditions may be carried by my child or ward. (i.e. bee sting kits, inhalers)

Name of medication(s)	Prescribing Doctor	Doctor's phone number

Amount to be taken	How is it taken?	When to be administered

Day(s) to be taken	Special Instructions

Signature of parent or guardian Date: